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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
VOL. 147 NO. 1, JANUARY, 1975

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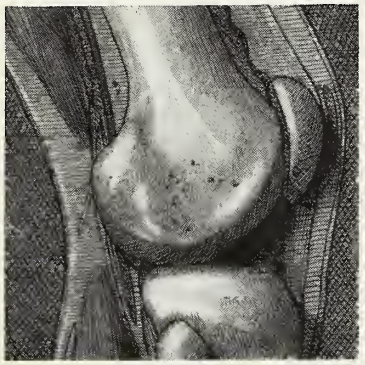
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WHEN FLU HITS AND HURTS

HERE Muscles and joints



Wherever it hurts, Empirin Compound with Codeine usually provides the symptomatic relief needed.

HERE Headache



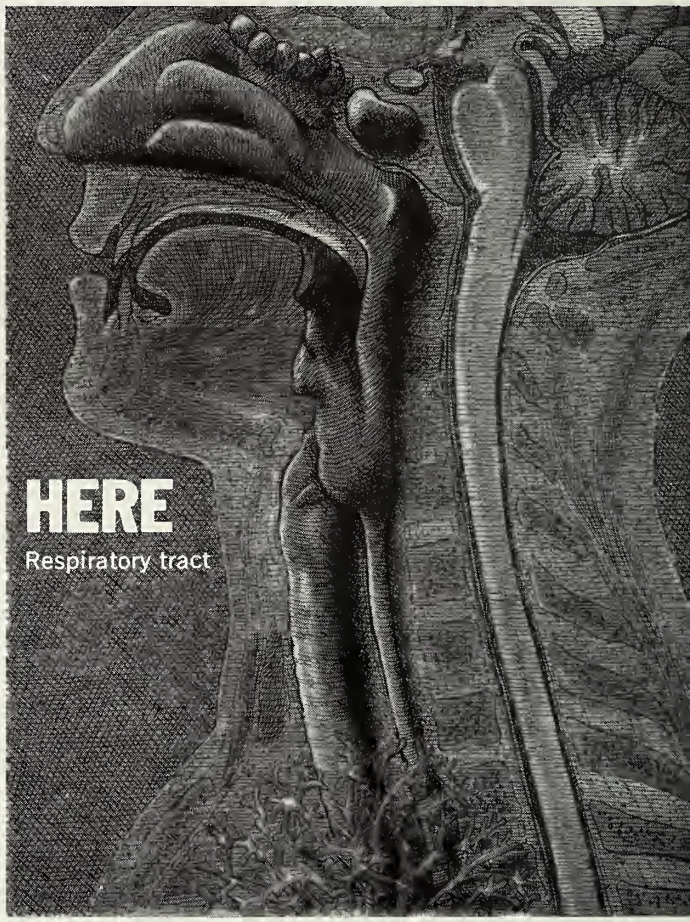
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BLUE SHIELD REPORT FOR *Illinois Physicians*

Faster Payments with Complete Claim Information

One of the studies underway in our service improvement program is to find ways to reduce delays in processing and payment of claims. Our Blue Shield Claims Department is currently receiving an average of 6,000 claims daily of which nearly 20 percent are delayed as soon as they arrive because errors and omissions are frequently made in the top portion of the Physician's Service Report.

The percentage of the errors and data omissions is high *in the first few entries of the report form.* Information is not being entered correctly, for example, on the first line requesting the Group and Member Identification Number. Without these correct numbers, a member's eligibility for benefits cannot be validated and the claim is initially delayed. Time must then be taken to verify a member's eligibility before anything further can be done to process the claim.

To avoid errors in supplying us with this essential information, please copy the Group and Membership Numbers exactly as they appear on the Blue Shield Membership Card. *Do not include the contract code number on the card.*

The box to the right on the first line of the claim form seems to invite the use of all types of numerical combinations which our claims examiners are often unable to decipher. It is intended only for a *patient's account number* which would be entered in a physician's office or clinic. The box has no significance for claim identification or processing purposes by our Plan.

Print or Type Names

On the following two lines, the complete first and last names of the patient and member should be printed or typewritten for legibility, and the spelling double-checked for accuracy. Then enter the member's *complete* address. Use the full line for the street, city and zip code. An address may often change from the one we have in our membership records.

Please also complete the information on sex, age, and patient's relationship to member. This data is often omitted, but it, too, is essential in processing the claim.

If the services involved the treatment of an injury in an accident, indicate date of the accident and where it occurred.

If the service was rendered in a hospital, complete the information for the admission date, discharge date, name and address of the hospital.

The entries that follow are equally important:

(1) In the space for diagnosis, please give us significant descriptions. Use standard medical nomenclature in describing a surgical procedure if an operation is performed.

(2) Give specific dates of service personally rendered by you, description of service performed and *fee charged for each service.* Also indicate whether or not fee has been paid by the patient.

(3) Please do not use another Physician's Service Report. We will be happy to supply you with your own properly imprinted forms at no charge.

If another physician has rendered a service, each must submit his own Physician's Service Report.

(4) Remember to complete the form with your signature and the date.

Medical Assistants' Handbook Helpful

Our new Medical Assistants' Handbook was prepared especially to help in the completion of our Physician Service Reports. A 23-page section of the Handbook begins with Completing the Claim.

It continues with general instructions on the completion of our reports and shows examples of completing claims for surgery, surgical assistance, fracture or complete dislocation, inhospital medical care, consultation, anesthesia, diagnostic X-ray, radiation therapy, psychiatric care, filing a Reciprocity claim, and mailing the claim.

Mailing of the Handbooks began the week of January 13, addressed to physicians' offices in the state. The books are being sent under 3rd class postage in our white Blue Cross-Blue Shield envelopes. Please watch for their arrival.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

SSA Emphasizes Identifying Sources of Laboratory Services

Instructions from the Social Security Administration emphasize the need for an attending physician to identify the sources of laboratory services on his billing statement or SSA-1490 Request for Medicare Payment form to avoid payment delays of Medicare Part B Claims.

If the SSA 1490 claim form is used, and a laboratory outside the physician's office provides the service, the laboratory must be identified in item 13 and the letters "IL" placed in item 7B. If the physician performs the laboratory service in his own office, an "O" is placed in item 7B.

When the source of the laboratory service is not identified, the Part B carrier must contact the physician for the necessary information, as the claim can no longer be routinely processed.

When a claim for services includes tests performed by a laboratory not certified in its specialty by Medicare, payment is denied. However, denial of payment for a test does not affect payment for the office visit.

Policy on Claims for Certain Therapies Amended

Payment to physicians by Part B Medicare carriers may be made under certain conditions for prolotherapy, joint schlerotherapy and ligamentous injections with schlerosing agents. New Medicare instructions amend previous policy and state that these therapies will be paid when treating occipito-cervical injury, sciatica and joint instability of the spine and other extremities. Claims for these therapies for conditions other than those above, will be denied.

Coverage of Long Term Cardiac Pacemakers

A recent Part B Medicare revision in the coverage of long-term cardiac pacemakers adds three new types to the conventional zinc-mercuric oxide battery-powered pacemakers: the lithium iodide battery; a rechargeable battery type and nuclear type. Of the four, only the zinc-mercuric oxide battery powered pacemaker was covered as a prosthetic device prior to January 1, 1973. With regard to the nuclear powered units, however, only those produced under licenses issued by the Atomic Energy Commission are covered. The power source is the most significant feature which differentiates pacemakers in terms of cost and operating life.

The zinc-mercuric oxide device has a life span of 24-36 months; the lithium iodide unit a life expectancy of at least 6 years; the rechargeable battery type, at least 7 years; and the nuclear powered units have a tested operating potential of at least 10 years.

Laboratories Recently Certified for Participation in Medicare Program

North Side Clinical Laboratory, Inc.
185 North Wabash Avenue
Chicago, Illinois 60601
Provider No. 14-8266

Fomaro Clinical Laboratory
7833 Cottage Grove Avenue
Chicago, Illinois 60619
Provider No. 14-8276

Associated Medical Laboratory
67 East Madison Street
Chicago, Illinois 60603
Provider No. 14-8277

F and M Medical Laboratory
4554 North Broadway
Chicago, Illinois 60640
Provider No. 14-8279

Grove Medical Laboratory
747 East 47th Street
Chicago, Illinois 60653
Provider No. 14-8280

Diagnostic Medical Laboratory
3359 West Chicago Avenue
Chicago, Illinois 60651
Provider No. 14-8281

E. A. Petrus, M.D. Laboratory
618 Edgemont
Park Ridge, Illinois 60068
Provider No. 14-8286

United Medical Systems, Inc.
740 North Rush Street
Chicago, Illinois
Provider No. 14-8283

Laboratories No Longer Certified:

Westside Clinical Laboratory
3808 West Roosevelt Road
Chicago, Illinois 60624
Provider No. 14-8161

International Clinical Laboratory
2165 North Milwaukee Avenue
Chicago, Illinois 60647
Provider No. 14-8225

Zeitlin X-Ray and Clinical Laboratory
2800 Milwaukee Avenue
Chicago, Illinois 60618
Provider No. 14-8098

IMJ

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Editorials



Physician Behavior

Physicians always have had an intimate relationship with life and death matters. On the whole, we try to give our patients sound advice and provide proper diagnostic and therapeutic measures. We like to believe in the credibility of our scientific information and the precision of our technical ability. When confronted with the unsatisfactory therapeutic results of a colleague, we do our best to use restraint and view the situation with objectivity and humility. After all, no one is perfect and I'm sure it is not difficult to recall some of our own poor results.

Moreover, we do not condone or wish to obscure physician incompetence or malpractice. But these activities are indulged in all too frequently by the more arrogant physician. Rarely can criticism of a completed treatment or diagnostic measure benefit the patient. Yet, here lie the seeds for future malpractice suits and criticism of the medical field in general.

Arrogance among physicians and surgeons reached its peak in Europe in the early decades of this century. Unfortunately, there remain remnants of this overbearing manner, especially among foreign graduates. Perhaps it is a cultural trait, but it does not set well with the average American who dislikes arrogance. Furthermore, the entire medical profession suffers.

My late father use to tell of a physician on Chicago's south side who actually reprimanded patients who had the audacity to go to another doctor. If they showed him the pills this doctor had prescribed, he threw them out of the window. Two or more decades ago, many surgeons were extremely arrogant, especially in the operating room. Many of these attitudes have changed, possibly because there is more competition.

The medical profession should continue in its efforts to assure high standards of intellectual and technical competence. Not only to protect patients, but also protect physicians from criticism based on emotional reactions and inadequate information.

We should try to rid ourselves of those physicians in our midst who endanger the public. It is the responsibility of each and everyone of us. But we should not do this by washing our dirty linen in public, especially before the news media.

More and more physicians are using the public forum to get publicity by criticizing their colleagues. Mr. Nixon's surgery is a good example. Those physicians who criticized the surgical procedure did not benefit Mr. Nixon, his physicians, or the medical profession. It could well be that we are a divided profession: general practitioners vs. specialists; or, perhaps, part-time vs. practicing physicians. A frequent area of criticism also concerns the physician's relationship to the community at large. Unfortunately, health care delivery to the underprivileged has become a political tool, a vote-getting device.

Health care delivery is a major industry and, unless we stick together, we may find ourselves working for the government, not ourselves.

T. R. Van Dellen, M.D.
Editor

The Role of the Detail Man

Opinion & Dialogue

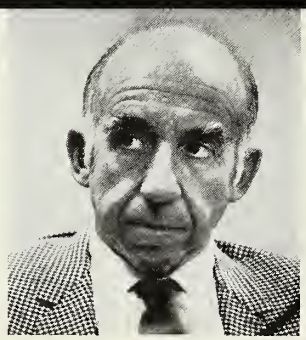


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

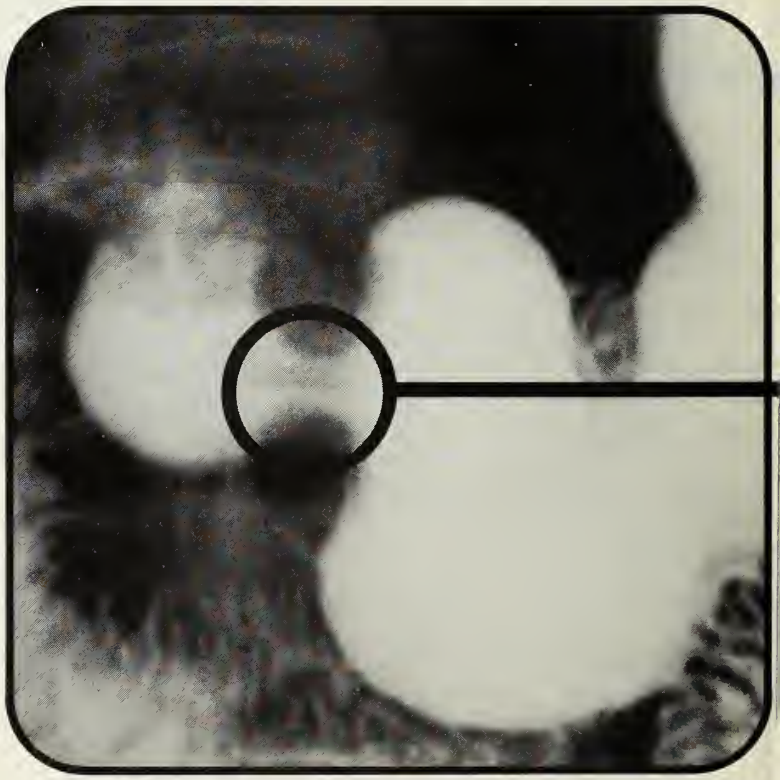
From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Upper functional G.I. disorders may be evidenced by epigastric pain

X-ray appears normal.



IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

454 R

Clinics for Crippled Children Listed for February

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for February by the University of Illinois, Division of Services for Crippled Children. The Division will conduct 21 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

February 5	Jacksonville-Norris Hospital
February 6	Hinsdale-Hinsdale Sanitarium
February 6	Sterling-Sterling Community Hospital
February 6	Anna-Union County Hospital
February 6	Flora-Clay County Hospital
February 6	Lake County Cardiac-Victory Memorial Hospital
February 10	Peoria Cardiac-St. Francis Children's Hospital
February 11	E. St. Louis-Christian Welfare Hospital
February 11	Peoria-St. Francis Children's Hospital
February 12	Champaign-Urbana-McKinley Hospital
February 13	Springfield-St. John's Hospital
February 13	Kankakee-St. Mary's Hospital
February 14	Chicago Heights Cardiac-St. James Hospital
February 18	Belleville-St. Elizabeth's Hospital
February 18	Rock Island-Moline Public Hospital
February 19	Springfield Pediatric-Neurolgy — Diocesan Center
February 19	Chicago Heights-St. James Hospital
February 20	Rockford-St. Anthony Hospital
February 20	DuQuoin-First Methodist Church
February 20	Blomington-Mennonite Hospital
February 20	Elmhurst Cardiac-Memorial Hospital of DuPage County
February 24	Peoria Cardiac-St. Francis Children's Hospital
February 25	Peoria-St. Francis Children's Hospital
February 25	Danville-Lake View Hospital
February 26	Rock Island Cerebral Palsy-Foundation for Crippled Children and Adults
February 26	Aurora-St. Joseph Mercy Hospital
February 27	Effingham-St. Anthony Memorial Hospital
February 28	Chicago Heights Cardiac-St. James Hospital
February 28	Evanston-St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

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nly she would diet, her blood gar might come down. Her high vels of blood insulin might come wn, too. This may be important the overweight diabetic since sulin is the "storage hormone" at transports glucose into adipose sue. Maybe the last thing the erweight diabetic needs to lower r blood sugar is a drug that stim-ates more insulin secretion. f dieting doesn't work in the over-eight, nonketotic, adult-onset abetic, consider adding DBI-TD.

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rnings: Lactic Acidosis: There have been nerous reports of lactic acidosis in patients eiving phenformin. This is an often fatal abolic acidosis, characterized by elevated ate levels, an increased lactate-to-pyruvate o, and decreased blood pH. In most cases, temia ranging from mild to severe was pres-. This may have been the result of dehydra-. In some patients who developed lactic dosis, serum creatinine was later within nor-limits when the patients were properly hy-ted. Observe the following specific warnings:

a. Impairment of renal function increases the sk of lactic acidosis. Perform renal function ests, such as serum creatinine, prior to phen-ormin therapy and annually thereafter. Phen-ormin is contraindicated in patients with mpaired renal function.

Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.

"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

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The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Take the Ball and Run

Portland, Ore., was the site of the 1974 AMA Clinical Convention this year, and housestaff from across the country were in attendance. Through both formal meetings and informal gatherings, these housestaff representatives communicated their ideas to members, delegates and officers of the AMA. In every case, the problems of housestaff officers were listened to with great interest, and while controversy and honest disagreement were present, there also was concern for the house officers' problems and attitudes.

As a result of these discussions, the AMA has taken a positive stance in support of housestaff, their ideas, and their problems. Specifically, the AMA has taken four significant steps to insure active housestaff participation at the decision-making level of national health care, to help housestaff solve many of their own problems, and to solidify the communications between the house officer and the practicing physician.

The AMA went on record in its support of active participation of housestaff in the AMA. To help this process, the Interns and Residents Business Session and the Committee on Housestaff Affairs have been combined. Because of this combination, there will be greater effectiveness in the communication of housestaff interests to the AMA and the public at large. Duplication of effort will be avoided, and greater efficiency in dealing with housestaff problems will be achieved.

Housestaff have been given complete control over the editorial policy of the AMA housestaff newsletter, within the bounds of factual accuracy and good taste. The newsletter may now become a forum for honest disagreement and exchange of views by housestaff. Without doubt, the newsletter will become a wealth of ideas both for the AMA and for the American health care system. Many house officers have creative and innovative thoughts about health care delivery which will be useful to all members of our society. It is hoped that these can be circulated through the newsletter, insuring their consideration in policy-making.

The AMA has elected to permit general circulation of all housestaff-written reports on various items of interest. Many of these reports already have been written and some of them distributed. With this new policy, the reports will become available to any interested individual or group. The resultant exchange of ideas will be most beneficial to housestaff seeking help, and other groups seeking guidance.

Probably the most significant support the AMA has given to housestaff has been in the area of financial aid. At Portland, the AMA decided to allocate close to $100,000 for this year alone for housestaff activities. In addition, *how* this money will be spent will be left largely to housestaff themselves. A budget will be created by housestaff members of the AMA with the aid and guidance of the AMA staff. The priorities given by the housestaff will then be taken into account, and the money appropriated accordingly. This freedom is not taken lightly by the housestaff representatives at the AMA, and work has already begun on planning the priorities of this budget.

Largely because of AMA funding in the past, interns and residents have been given the opportunity to represent housestaff to the National Board of Medical Examiners, the Liaison Committee on Graduate Medical Education, the Institute of Medicine Social Security Reimbursement Study, the HEW "Definition of a House Officer" study, and the HEW-AMA PSRO Criteria Development Project. Housestaff participation in these projects will continue with the renewed funding.

AMA funds helped to finance an in-depth study of the foreign medical graduate and his problems. The report of this committee contains more than 100 recommendations meant to help solve many of the problems the FMG faces.

AMA funds have enabled house officers to testify before Congress on matters relating to the health care field. One senator was surprised to discover during this testimony that the term "housestaff" did *not* include orderlies, housekeeping personnel, etc., but only included physicians. With the many important laws dealing with health care coming before legislators, it is essential that house officers maintain an input into the decision-making process. The AMA has insured this input through its continued funding of housestaff affairs.

The AMA has supported the concept of due process for housestaff, and is taking steps to include that concept in the "Essentials of an Approved Internship" and the "Essentials of an Approved Residency." "Guidelines for a Model Housestaff Contract" have been approved and shortly will be available to housestaff across the country.

The AMA has again demonstrated that it is interested in housestaff. In part, this interest is due to the fact that housestaff physicians of today will be practicing physicians and members of the AMA tomorrow. But the larger and more important reason for the AMA's interest is that interns and residents, *as housestaff officers,* have much to contribute to organized medicine. Because of their age and the nature of their practice, housestaff members very often have a different perspective on matters of health care. It is this difference of perspective that makes their contribution to the decision-making process so valuable. In a similar fashion, housestaff are interested in the AMA. As the largest single vehical for organized medicine with a respected influence at the national legislative level, it offers housestaff an opportunity to put their views into action. Made up of a cross-section of practicing physicians, *all of whom* were house officers at one time in their lives, the AMA can give valuable assistance and guidance to the house officers who wish to make a contribution to the betterment of the health care delivery system.

The AMA has given firm support to housestaff and their concerns. It is now time for housestaff to take the ball and run. There is much to be accomplished and many stumbling blocks. But with the AMA supporting housestaff, far more of these goals can be achieved than anyone can imagine. ◄



medical legal review

Patient Right to Acquisition of Medical Records

By James L. Fletcher/ISMS Legal Counsel

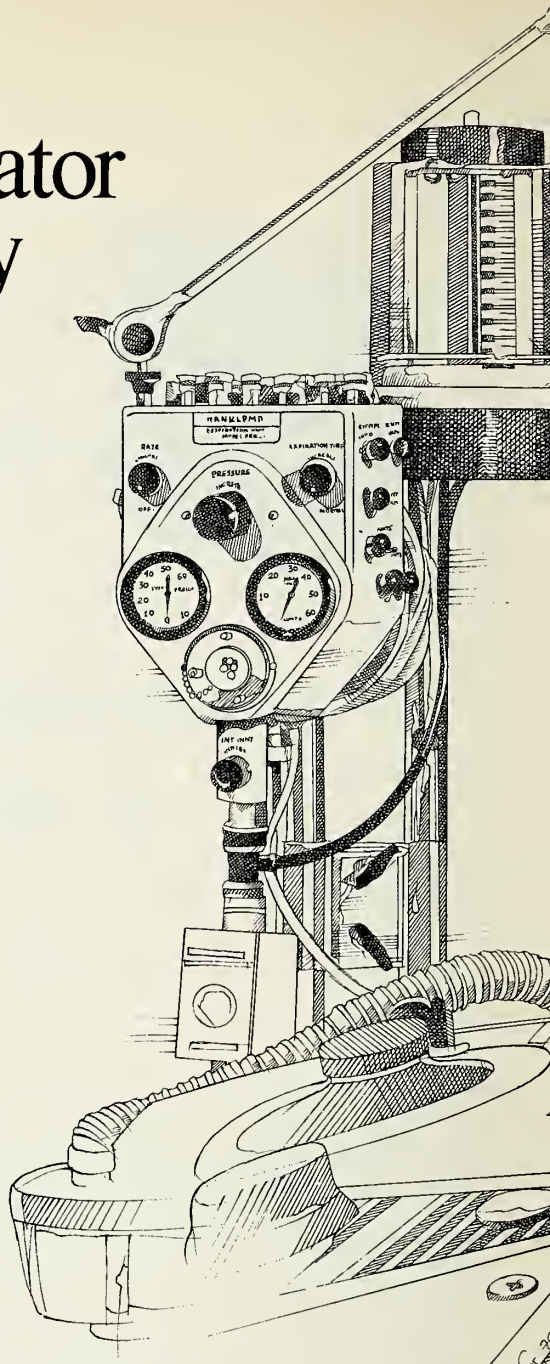
Illinois law does not require a physician to turn over his records to a patient upon that patient's request. These records are considered the property of the physician and he may retain them as he wishes. The Judicial Council of the AMA, in its *Opinions and Reports* has considered this question:

> "The Principles neither intend nor require that a physician give a copy of his records to his patient. These records are primarily the physician's own notes compiled during the course of diagnosis and treatment so that he may review and study the course of the illness and his treatment. The records are medical and technical, personal and often informal. Standing alone they are meaningless to the patient but of value to the physician and perhaps to a succeeding physician. The patient, however, or one responsible for him, is entitled to know the nature of the illness and the general course or regimen of therapy employed by his physician. The extent to which the physician must advise his patient may be limited by the nature of the illness and the character of the patient. The physician in advising his patient must always act as he would wish to be treated were he in a like situation." (Section 9, paragraph 4)

In a recent 1974 Illinois appellate court ruling, it was ruled that a patient is entitled to be given information by a treating physician concerning patient's condition. The court stated that a physician has a duty to disclose medical information to a patient or patient's agent upon request.

While, it seems to me, a physician may at times face unwanted and undeserved negative publicity if he should choose to refuse to tender to a patient certain medical records, nonetheless he not only has a legal right to so refuse, but the *Opinion and Reports* of the AMA emphasize, as quoted above, that quite often the best interests of the patient are not really being served when that patient is given total access to his medical records. ◄

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R-epinephrine	++	++	+++
Isoproterenol		++++	+++++
Isoetharine		+	+++

*Ziment, I.: Resp. Therap. 4:51, May-June, 1974.

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Should not be administered along with epinephrine or other sympathomimetic amines, since these drugs are direct cardiac stimulants and may cause excessive tachycardia. They may, however, be alternated if desired.

Use in Pregnancy: Although there has been no evidence of teratogenic effects with these drugs, use of any drug in pregnancy, lactation, or in women of childbearing potential requires that the potential benefit of the drug be weighed against its possible hazard to the mother or child.

Precautions: Dosage must be carefully adjusted in patients with hyperthyroidism, hypertension, acute coronary disease, cardiac asthma, limited cardiac reserve, and in individuals sensitive to

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Illinois Medical Journal

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Reliability of Throat Cultures in Tonsillitis

By Annette M. Lotter M.D. and George W. Allen, M.D./Chicago

Modern management by physicians most often concerned with the treatment of pharyngitis, places primary emphasis upon the prevention of the non-suppurative complications of Beta-hemolytic streptococcal infections. Success in treatment has been judged primarily by the ability of a particular antibiotic regimen to eliminate Beta-hemolytic streptococcus from the throat culture taken following treatment. It is reasonable to assume that complete elimination of these bacteria from the patient is necessary to prevent recurrance of infections and the development of rheumatic fever in some cases. It becomes important, therefore, to determine the reliability of throat cultures taken in the usual way, by wiping the surface of a small portion of the tonsils and pharynx, to detect the presence of potentially pathogenic organisms. This was the principal aim of the present study. We also wanted to see how the evaluation of results of a drug study might vary depending on the manner in which cultures were taken. A previous study by the authors demonstrated the presence of Beta-hemolytic streptococcus and staphylococcus aureus in a high precentage of cases when cultures were taken from the crypts of excised tonsils.[1] Most of the staphylococcus aureus isolated were resistant to penicillin but sensitive to erythromycin and tetracycline. Erythromycin was chosen for the present study because most of the cases were children and it was desirable to avoid tetracycline staining of the teeth. Also, erythromycin was shown to be approximately as effective as clindamycin and penicillin in treatment of streptococcal infections by Levine and Berman, although there was a trend in favor of clindamycin.[2] These authors showed that with culture-proven Beta-hemolytic streptococcal infections, both erythromycin and clindamycin





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caused rapid elimination of the organisms. When cultures were taken two to six days after onset of therapy only three out of 52 (5.8%) were positive in the erythromycin group and none of the 47 (0%) were positive in the clindamycin group.

Methods

A study was made of 100 consecutive cases of children having tonsillectomy and adenoidectomy. These were mostly children of low-income families seeking treatment for severe throat disorders. After they were first examined a throat culture was taken and they were started on erythromycin in doses of 125mg to 250mg four times a day. Tonsillectomy and adenoidectomy were performed 4 to 10 days later. The antibiotic was continued until the time of surgery. At operation, a second culture was taken from the surface of the tonsils after the patient was anesthetized. After the tonsils were removed, one of them was incised and a third culture was taken from the cut surface. These cultures were processed in the usual way in the clinical laboratory of either of two large, well-equipped general hospitals.

Results and Discussion

Beta-hemolytic streptococcus, Staphylococcus aureus and Hemophilus influenzae were the most frequent potential pathogens found. A comparison of the incidence of these organisms in each of the three culture groups is listed in Table 1.

Table 1
Incidence of Positive Cultures under 3 Different Conditions

	Beta-strep	Staph. aureus	H. influenzae
Before treatment with erythromycin	14	33	2
Immediately before operation	25	23	6
From interior of excised tonsil	34	34	7

From the results it can be concluded that many pathogenic organisms present in tonsils are not detected by cultures of the surface of the tonsils. Secondly, cultures taken from the surface of the tonsil under optimal circumstances (i.e., with the child completely still and the tonsils fully exposed so that bacteria can be expressed from the crypts) are more apt to detect pathogens than are cultures taken in the usual manner.

Erythromycin does not appear to be very efficacious in eliminating either Beta-hemolytic streptococcus or Staphylococcus aureus from the tonsils when given under the conditions of this study compared to the rapid reversal of positive cultures reported by Levine and Berman.[2] It is not valid to conclude that erythromycin is not effective treatment for streptococcal pharyngitis because it might have been more effective if given for a longer time. Also, there was no confirmation that the patient actually received the medication.

A slightly different analysis of the data leads to similar conclusions. Of the 34 cases with streptococcus positive cultures from the cut surface of the tonsil, only 21 of the same cases had positive cultures immediately before operation. Of 14 streptococcus positive office cultures, 10 of these same cases remained positive on culture of the cut surface of the tonsil in spite of erythromycin treatment. Of 33 Staphylococcus aureus positive office cultures, 21 of these same patients remained positive on culture of the cut surface of the tonsil.

Summary

It was found that throat cultures taken in the usual way are much less likely to reveal pathogenic bacteria than cultures taken from the tonsils in the anesthetized child which in turn are less likely to reveal these organisms than cultures of the parenchyma of the excised tonsil. The discrepancy is great enough to invalidate ordinary throat cultures as a guide to adequacy of drug therapy. ◄

Acknowledgement

The authors extend grateful acknowledgement to Dr. John Passmann, Grant Hospital, Department of Pathology and Dr. Joseph Wizgird, Henrotin Hospital, Department of Pathology for their help in evaluating the presence of organisms on the histological sections of the excised tonsils.

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2. Levine, W. K. and Berman, J. D.: "A Comparison of Clindamycin and Erythromycin in Beta-Hemolytic Streptococcal Infections." *J. Med. Assn. of Georgia* 61: 108-111, 1972.

Psychiatry in a General Hospital Emergency Room

By Mark A. Amdur, M.D. and Edward N. Tuder, M.D./Chicago

This is a study of emotional disorders in an urban general hospital emergency room. The various studies to be described were conducted at the Northwestern University McGaw Medical Center. Two general hospital emergency rooms and a Veteran's Hospital admitting office were the clinical settings. These hospitals are located on Chicago's near North Side. At all three reception sites an initial evaluation is made by an intern or non-psychiatric house staff officer. A psychiatric consultation is requested for cases he deems appropriate.

Description of the Studies

A prospective study was conducted during the first six months of 1972. This consisted of a questionnaire administered by one of the authors to each individual on whom he consulted at the three sites. This represents essentially a randomized sampling of the population served. The total number of questionnaires was 68.

A retrospective study was conducted by both authors. This consisted of a review of every ER chart of one of the hospitals (Wesley Pavilion) for a six-month period (January-June of 1972). Although all charts were reviewed, data was collected on only three types of charts. These three categories are referred to as: "psychiatric", "med-psych", and "random". The "psychiatric" group consisted of all persons for whom a psychiatric consultation was sought and all persons admitted to the Intensive Care Unit from the ER with the diagnosis of "overdose." The total number of complete "psychiatric" charts was 170. Partial information was available on an additional 76 charts. The "med-psych" group consisted of all patients discharged with a primary psychiatric diagnosis made by a non-psychiatric house staff officer with no psychiatric consultation requested. The total number of charts in the "med-psych" group was 154. Individuals signed out by non-psychiatric house staff officers with the diagnosis of "alcoholism' were not included. The "random" group was a statistically valid sample of all persons visiting the ER of Wesley Pavilion during June of 1972. The total number of charts in the "random" group was 160.

MARK A. AMDUR, M.D. and EDWARD N. TUDER, M.D., at the time of writing, were third yeor residents in psychiatry ot Northwestern University School of Medicine and are presently as Associates in the Department af Psychiatry at Northwestern University School of Medicine.

Findings

Only data which is felt to be relevant to service design or which distinguishes the psychiatric population from other populations will be discussed. Data will be presented as it relates to specific issues.

A. *Prevalence of Past Psychiatric History*

Of individuals interviewed in the prospective study 73.5% had a history of at least one previous psychiatric hospitalization; 8.8% had a past history of outpatient psychiatric treatment only; and 17.6% had no past psychiatric history.

B. *Diagnostic Categories*

In the "med-psych" group, anxiety and hyperventilation reactions accounted for 72% of the diagnoses. Psychophysiological and conversion reactions accounted for 17%. Depression accounted for 5%, and drug abuse and "other" accounted for 6%.

In the "psychiatric" group, psychotic disorders accounted for 32%. Depression and suicidal gestures accounted for 26%. Alcoholism accounted for 10%. Anxiety and hyperventilation reactions accounted for 9%. Psychophysiological and conversion reactions accounted for 8%. Drug abuse accounted for 6%. Organic brain syndromes constituted 4% of those seen by a psychiatric consultant. Personality disorders accounted for 2%. "Other" diagnoses were entered for 3%.

In the prospective study, where each individual was specifically questioned regarding alcoholism, the prevalence of alcoholism was 29%.

C. *How Individuals Perceive Their Problem*

A content analysis of chief complaint, entered as a direct quotation by a clerk, was made on all the "psychiatric" ER charts. Of these individuals subsequently seen by the psychiatric resident, 50% perceived their problem as emotional upon entering the ER. The remaining 50% stated their complaint in terms of altered physiologic functioning (35%) or stated simply: "I want to see the doctor." (15%).

D. *Marital Status (see table below)*

State of Illinois (1970 Census)	Married	Single	Widowed	Sep/Div
Male	65.4	28.7	3.2	4.2
Female	60.5	22.9	12.6	6.3
"Random" Sample of ER	41.0	43.3	3.9	11.8
"Med-Psych"	38.0	42.5	7.1	12.4
"Psych"	27.5	46.7	6.4	19.3

E. *Presence of Accompanying Social Network*

59% of the individuals in the prospective study presented at the ER in the company of a close friend or relative.

F. *Employment Status*

	Employed	Unemployed
City of Chicago (1972 approx.)	95 %	5 %
"Random" group	81.1%	18.9%
"Med-Psych" group	66.0%	34.0%
"Psychiatric" group	54.5%	45.5%

G. *Time of Presentation*

	8am-4pm	4pm-12am	12am-8am
"Random"	48.7%	41.4%	9.9%
"Med-Psych"	47.1%	35.7%	17.2%
"Psychiatric"	46.3%	39.4%	14.3%

H. *Frequency of Primary Psychiatric Diagnoses in the ER*

The total number of ER visits for all reasons for the six month period studied at Wesley Pavilion was 9,537. Of these 246 (2.5%) had a psychiatric consultation. An additional 154 (1.5%) individuals were discharged with a primary psychiatric diagnosis but with no psychiatric consultation.

Discussion

A. *Past Psychiatric History*

Nearly ¾ of those persons seen by the psychiatric residents had been previously hospitalized. People with a history of outpatient treatment only were markedly under-represented. The implication is that people who have been hospitalized tend to return to the hospital in times of crisis.

Persons present to the ER more often than not with the expectation of hospitalization. The consulting psychiatrist, often with a bias for community care rather than hospitalization, must deal with these expectations. He must carefully assess the individual's social network for the degree of tolerance it has for deviance. This factor, more than the absolute magnitude of psychopathology, often determines the necessity for eventual hospitalization. The social network must be adequately supported if home care is to be requested. Quality back-up programs must be available to deliver on the promise of meaningful community care: 24-hour availability; no waiting lists; partial hospitalization; emergency lodgings; "holding areas" in the ER; and a capacity for home visitation.

The ER consultant should identify and strive particularly hard to avoid hospitalizing those individuals without previous psychiatric in-patient treatment.

B. *Diagnostic Categories*

Anxiety and hyperventilation were particularly popular diagnoses in the "med-psych" group. Young adults complaining of chest pain or shortness of breath were particularly likely to receive this diagnosis. This was, however, a diagnosis of exclusion, and most of the patients had a number of procedures such as CBC, chest X-ray, EKG, or blood gases. In addition to being an uneconomical diagnostic approach to the problem of anxiety, this also reinforces the patient's medical preoccupation and makes him less amenable to a meaningful psychiatric consultation. Taking note of the patient's age, sex, marital and employment status, plus some simple questions related to current life stresses, might point to a psychiatric consultation before an extensive emergency medical workup is launched.

Grossly psychotic and suicidal patients were apparently recognized readily and promptly referred to psychiatry; 32% of the persons seen by the psychiatric consultant of Wesley's ER received a psychotic diagnosis. It is significant that adjustment and situational reactions were rare diagnoses. This suggests that relatively stable individuals reacting to situational stress do not seek help in general hospital emergency rooms. The diagnosis of alcoholism was made in only 10% of the psychiatric consultations at Wesley. The prospective study, in which each person was asked specifically about a history of alcoholism,

revealed a prevalence of 29% for alcoholism. Consequently, any service design must include of itself or have immediate access to alcoholic detoxification, halfway houses for alcoholics and medical resources for the medical complications of alcoholism.

C. *Patient's Perception of Problem*

From the content analysis of all ER "psych" charts, it was discovered that ½ of the individuals for whom a psychiatric consultation was requested perceived their problems in terms of altered physiology. The main implication of this is that the emergency psychiatric service cannot be far removed from a general hospital ER, since people perceiving their problems in medical terms cannot be expected to present themselves to a purely mental health facility.

D. *Marital Status*

Married persons are under-represented in all of our categories of ER patients. This, in part, reflects the geographic setting in which the medical center is located. According to the 1970 census, the area surrounding the medical center has the greatest percentage of persons living alone of any area in the City of Chicago. The "psychiatric" group in particular is markedly over-represented by persons who are single, widowed, separated, or divorced. Only 27.5% of the "psychiatric" group were married as opposed to approximately 60% for Illinois as a whole, and 41% for the "random" sample. The isolated social status suggested in this data has strong implications for service design in that it tends to greatly decrease the dispositional alternatives for persons seen in the ER. The need for ready access to a supportive environment other than the kinship network or in-patient setting is apparent.

E. *Presence of Accompanying Social Network*

Despite the high degree of social isolation suggested in data on marital status, one finding from the prospective study was encouraging. 59% of the individuals in the prospective study presented at the ER in the company of a close friend or relative. The remaining 41% came alone or were brought by the police. This suggests that although the individuals in the "psychiatric" group tend to be single and living alone, when they enter into a crisis they somehow manage to attract to them, at that time, significant persons from their family and friendship networks—networks that may have been dormant.

The ER intervention can clearly consist of more than a simple triage decision (admit, commit to state hospital, or send home). In a majority of cases, the consulting psychiatrist will be able to make not only a traditional evaluation of the individual in crisis, but also an evaluation of the intactness of the individual's social network. Our ER service is now designed with the expectation that much of our work will be with families.

F. *Employment Status*

As with marital status, employment status was seen as another measure of how well an individual was integrated with the social surroundings. Again the data suggests that individuals in the "psychiatric" group are relatively unintegrated. During the period of the study, unemployment in Chicago fluctuated between 4% and 5%. 81.1% of the "random" sample was employed. 54.5% of the "psychiatric" group was employed. The "med-psych" group was intermediary. One implication would be that relatively few of these individuals would be likely to be able to accept a referral to a private psychiatrist since they would have neither the requisite funds nor health inusrance.

G. *Time of Presentation*

Knowing the times of presentation allows one to estimate the time for greatest service demand and to staff accordingly. It might be wise to have some staff persons commence their 8-hour day at noon or 2 pm. Slightly less than half of all psychiatric consultations came during normal business hours.

H. *Frequency of Primary Psychiatric Diagnosis*

The prevalence of labelled psychiatric illness in the ER of Wesley Pavilion is 4%. This represents the total of the "psychiatric" group (2.5% of all ER visits) plus the "med-psych" group (1.5% of all ER visits). With education of the evaluating intern as to the identification of psychiatric disorders and with cultivation of referral sources, one may expect the prevalence of psychiatric problems to increase considerably.

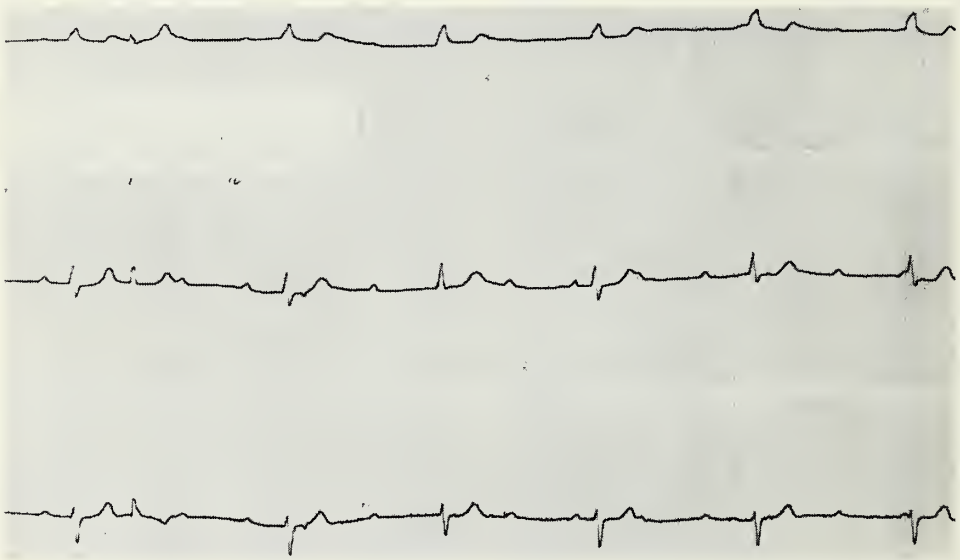
Conclusion

This study focused on persons presenting in an urban general hospital emergency room who were signed out with a psychiatric diagnosis. These persons were also compared to a random sample of all persons coming to the emergency room.

(Continued on page 54)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., James V. Talano, M.D., Sarah Johnson, M.D. and Rolf M. Gunnar, M.D., M.S./Section of Cardiology, Loyola University Stritch School of Medicine



This is a 66-year-old lady who had a severe episode of dyspnea and dizziness upon arising from bed one morning two weeks prior to admission. From that day to admission she had marked dyspnea on exertion. She was basically comfortable only at rest. She denied any syncopal episodes and chest pains. Her physical exam showed bilateral moist crepitant rales in the lung bases. The simultaneous 3 lead rhythm strip was taken (leads I, II, and III).

Questions:

1. **The lead I, II, and III rhythm strip shows:**
 A. Atrioventricular dissociation.
 B. Idioventricular rhythm.
 C. Occasional sinus capture beats.
 D. Occasional retrograde atrial conduction.
 E. All of the above.

2. **The treatment would include:**
 A. Quinidine.
 B. Pronestyl.
 C. Digitalis.
 D. A demand pacemaker.
 E. His bundle recording.

(Answers on page 90)

Allergy and Secretory Otitis Media

By Seymour M. Warshaw, M.D. and Leon Unger, M.D./Chicago

One of us, having practiced allergy for many years, and the other a relative newcomer to allergy and with a background in otolaryngology, are quite cognizant of the fact that the two specialties have many interests in common, with chronic secretory otitis media being one of them.

Chronic secretory otitis media, the retention of serous or mucoid fluid in the middle ear, is the most common cause of hearing loss in children. This retention following an upper respiratory infection or airplane trip is usually self-limiting or easily resolved, but fluid remaining in the middle ear over a month is generally the result of an underlying condition. Special attention to the history pertaining to ear and hearing difficulties, along with careful otoscopic examination reveals many cases of chronic secretory otitis media among our allergic patients. Very often this is an ancillary finding.

Obstruction of the eustachian tube by adenoid hypertrophy probably is the most common cause of this condition in children. Tonsillectomy and adenoidectomy with myringotomies have often effected a cure. In some cases fluid persists following this procedure. In these instances, other causes should be sought. Low grade middle ear infection with metaplasia of middle ear mucosa, deviated nasal septum, sinusitis, poorly functioning or malformed eustachian tubes along with allergy have been associated with secretory otitis. The use of antibiotics in acute upper respiratory infections and in acute otitis media has also been suggested as a possible factor in causing this condition.



SEYMOUR WARSHAW, M.D., an otolaryngalagist and allergist, is a graduate af Indiana University Medical Schaal. Dr. Warshaw is a member of the Chicaga Saciety af Allergy and American College af Allergists.



LEON UNGER, M.D., an allergist and internist, is the authar af numeraus baaks and articles. He is a past president af the American College af Allergists, Chicaga Saciety af Allergy and Illinais Asthma Faundatian. Dr. Unger is certified by the American Baard af Internal Medicine and the American Baard af Allergy and Immunalagy as well as a Fellaw in the American College af Chest Physicians, American College af Physicians, American College af Allergists and American Assaciatian af Clinical Immunalagy and Allergy.

Studies suggest allergy as one cause of secretory otitis media. Monkeys passively sensitized to ragweed pollen have developed secretory otitis media following instillation of ragweed pollen in their eustachian tubes, whereas non-sensitized monkeys did not.[1]

Hearing loss is the most common symptom. Earache, tinnitis, dizziness, behavioral problems and learning difficulties also may be symptoms. In some cases, the fluid can be seen through the eardrums. Dull or thickened eardrums are often seen, but the condition can exist with normal eardrums and no symptoms. A conductive hearing loss is most commonly found.

Tonsillectomy and adenoidectomy is the treatment of choice only when careful examination shows hypertrophy of the adenoid tissue to be the cause of eustachian tube obstruction. If no such obstruction is found or if there is persistance of the fluid following adenoidectomy, further search for the cause of the condition is indicated.

Careful history and physical examination from the allergic standpoint is very important in these patients. A history of hay fever, "sinus", nasal obstruction, chronic cough, bronchitis, wheezing, hives, eczema, colic, migraine headaches, or nasal polyps suggests an allergic origin. A family history of these also is significant.

A pale, boggy nasal mucosa is usually considered allergic; however, nose drops, medications, and polluted environment can alter the appearance of the mucosa enough to make the diagnosis more difficult. Eosinophilia in the nasal smear and blood suggests allergy. Bloody fluid in the middle ear is generally considered to be of allergic origin.

Long term therapy with anti-histamine/decongestants along with careful insufflation of the

(Continued on page 90)

surgical grand rounds

Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 18, 1973.

Pancreatic Neoplasm in a 13-Year-Old Girl

Dr. Dennis Olson: A 13-year-old girl was taken to her family physician because her mother had noticed a mass in her upper abdomen. The patient admitted at this time that she had noted the mass two years earlier, but she had been unconcerned about it. She had not suffered abdominal pain, had not lost weight, and was without other gastrointestinal symptoms. She was admitted to a hospital and after appropriate study, an exploratory laparotomy was performed with a preoperative diagnosis of pseudocyst to the pancreas. A large cystic mass was found in the head of the pancreas which measured approximately 10 centimeters in diameter. Transduodenal biopsy was performed and, on the basis of a frozen section and diagnosis of pseudocyst, cyst-duodenostomy was performed. The patient made an uncomplicated recovery. However, review of the permanent microscopic sections revealed neoplastic change which suggested the presence of a pancreatic cystadenoma. She was transferred to the Northwestern Memorial Hospital for definitive therapy.

When she was admitted, she appeared pale but was otherwise a well nourished and developed 13-year-old girl. A healing right paramedian incision was present. Abdominal examination was otherwise unremarkable.

Laboratory studies included: Hematocrit, 30%; white blood count, 5,000 cm^3; BUN, 15 mg% and blood sugar, 100 mg%. Serum bilirubin and liver enzymes were within normal limits. A radiologic study of the stomach and duodenum was obtained.

Dr. Leonid Calenoff: We have two sets of upper gastrointestinal examinations, the first performed before the surgical exploration at the other hospital, the second set after admission to Northwestern Memorial Hospital. On the first examination, there is marked widening of the duodenal loop with, at the same time, upward and lateral displacement of the gallbladder which



Figure 1. Upper gastrointestinal roentgenograms demonstrated marked enlargement of the duodenal loop.



Figure 2. After transduodenal drainage, the duodenal loop decreased in size and a fistulous tract was visualized.

was examined at the same time (Fig. 1). In addition to the widening of the loop, there is narrowing of the lumen of the duodenum and effacement of the mucosa. The findings are consistent with a cyst or a tumor of the head of the pancreas. The second examination shows a decrease in size of the space occupying lesion within the widened duodenal loop. There is now an extraluminal collection of barium originating at the second portion of the duodenum and continuing towards the pancreas. This is a fistula tract or a surgical marsupialization (Fig. 2).

Dr. Olson: To determine if this mass was still cystic and to obtain an estimate of its size, ultrasound studies were performed.

Dr. Robert Henkin: Ultrasonic techniques are a derivation of sonar techniques and permit us to look at cross-sections of the patient, one or two mm in thickness, either transverse or longitudinal. It's an entirely new view of living anatomy. The atlases of anatomy have been drawn from cadavers, frozen and sliced with a bandsaw.

The lesion in this patient gave an image of a typical pancreatic pseudocyst. The characteristic of any cystic lesion on ultrasound is that it has no internal echoes. This cyst was approximately six centimeters above the umbilicus which is the landmark that we use in the anterior view. On the longitudinal cut, the cystic lesion was detected six centimeters to the right of the midline. This lesion also had multiple internal echoes so this was not a simple cyst. Since the cyst had been drained, we didn't know whether or not there was debris from the drainage. However, these findings are compatible with a tumor as well as a cyst with internal debris. As a result, this was reported as a possible cyst with internal debris, but also consistent with a cystic tumor.

Dr. John Beal: This is a useful technique that is not invasive, easily accomplished, and quickly done. What other lesions can this be applied to?

Dr. Henkin: Urologists have employed this method to determine if lesions of the kidney are cystic with a reported accuracy rate of approximately 90%. It is a very useful technique for renal biopsy as well, because one of the transducers, which are the sound generators, has a central hole through which a needle can be passed and guided into the cyst for biopsy. This procedure is useful for the detection of aortic aneurysm, since the aorta is generally quite well visualized and one can determine the size of the aorta or an aneurysm. To the best of our knowledge, there are no ill effects in adults. It is a painless procedure and is accepted well by patients. Obstetrical applications include assessment of fetal age and placental localization. The heart station has employed ultrasound for information on ventricular motility, and in valvular disorders of the heart.

Dr. Olson: With a preoperative diagnosis of benign cyst adenoma of the pancreas, she was taken to the operating room on August 1. When the abdomen was opened, a mass was found which occupied the head of the pancreas within the sweep of the duodenum and measured approximately eight centimeters in diameter. A Kocher maneuver was performed, raising the mass into the operating field. The mass appeared well encapsulated at this point and the liver was normal. The duodenum was divided at the pylorus and the pancreas was transsected at the midportion of the body. A probe was inserted into the distal pancreatic duct. The jejunum was transsected and the specimen was dissected from the superior mesenteric vessels. The operative procedure included a cholecystectomy and hemigastrectomy. Gastrointestinal continuity was reestablished with pancreatical-jejunostomy, an end-to-side choledochojejunostomy, and a gastrojejunostomy.

Dr. Hector Battifora: On opening the duodenum, one could see a deep crater. On section, the tumor appeared round, abutting in the duodenal mucosa and had a deep irregular crater

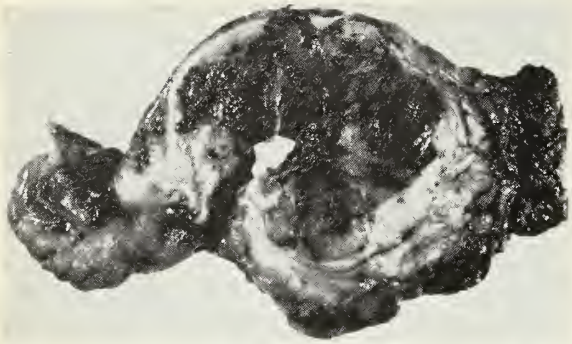


Figure 3. Gross photograph of cross section of surgical specimen. A deep ulcer crater penetrates the tumor. A thin rim of pancreatic tissue remains around most of the neoplasm.

(Fig. 3). The tumor had focal areas of hemorrhage, areas of more dense fibrous tissue, but generally was semifirm. With the exception of this crater, no cystic spaces could be found. The pancreas around the tumor appeared preserved but flattened. At many points, the tumor seemed to invade the pancreas and did not have a true capsule. Sections taken from the periphery show the tumor blending with the pancreatic tissue at many points. The histology of this tumor is unique and different from tumors of the pancreas seen in adults. It is made up of fairly uniform cells, forming in many places small glandular structures. The most prevalent pattern, however, is small masses and cords. In areas, abundant mixoid connective tissue reminiscent of mixed tumors of salivary gland were present. In other areas, the tumor was highly vascular and the cells formed anastomozing cords simulating islet cell tumors (Fig. 4). The cells are quite uniform, pleomorphism rather minimal, and mitoses are rather scant. In some foci, the cells contained eosinophilic granules which looked and stained very much like zymogen granules. So then we have a tumor that has features that are suggestive of an acinic cell tumor as well as features suggestive of an islet cell tumor.

Electronmicroscopy did not reveal granules of islet cell type. Instead it confirmed the presence of zymogen granules in most of the tumor cells.

In conclusion, the histology of this tumor is rather unique. Similar tumors have been seen in children and have been designated with a variety of names. We chose to use the term Infantile Carcinoma of the Pancreas.

Dr. Olson: She did well postoperatively and was able to start school four weeks after the operation. In review of the world literature, we found 22 cases of malignancy of the pancreas in children under the age of 16 years. A majority of these were reported to be of islet cell origin and only six could be found that had the pathologic features that Dr. Battifora has described. The pancreatic neoplasms usually present with abdominal pain and abdominal mass. Occasionally, other symptoms occur that are related to extension of the tumor, such as jaundice. The diagnosis has been made at laparotomy or autopsy in all cases. Five other patients have been treated by pancreaticoduodectomy and lived from three to 16 years. All of these patients were reported to have islet cell tumors. Only one child has been reported who was subjected to pancreaticoduodenectomy for an infantile carcinoma of the pancreas and that patient died in the immediate postoperative period. The remaining patients died within ten months of the time diagnosis was made.

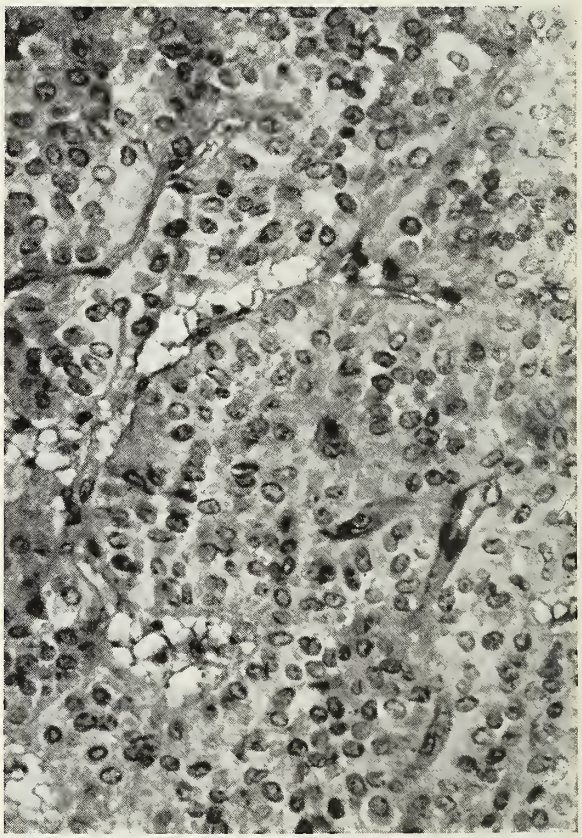


Figure 4. Medium power photomicrograph showing resemblance to islet tissue.

Dr. Beal: Dr. Battiffora, do you feel you have established that this is a malignant tumor?

Dr. Battifora: I cannot even be sure of that. We know that tumors with the same histology have been shown to metastasize. It is thus difficult to believe this one to be a benign tumor. There have been cases of similar tumors in children

(Continued on page 90)

The Impact of Laparoscopy in the Community Hospital

By Asuncion Imperial-Hizon, M.D., and Robert C. Stepto, M.D., Ph.D./Chicago

Laparoscopy is a method of endoscopic examination of the peritoneal cavity through the anterior abdominal wall after establishment of pneumoperitoneum. It is the purpose of this paper to present and evaluate the pros and cons with regards to the present use of the laparoscope in our hospital, after its introduction in 1970.

It is well known that laparoscopy is very useful in the diagnosis of obscure pelvic pathology and infertility and is being used exclusively for tubal sterilization. However, up to the present time many physicians, including some gynecologists, are not knowledgeable about the instrument and the possible complications that may occur in its use and how to prevent them. If all the complications of the laparoscopy are reviewed, it will be noted that most of them are preventable. Because of its popularity, in sterilizing a large number of patients in many community hospitals it is important to emphasize that the laparoscopist should be aware of the details of the instrument, including a basic knowledge on electrical conduction. There should be a team of well trained assistants, anesthesiologists and nurses. Lastly, cases should be properly selected and made sure there is no contraindication to its use.

History

The first laparoscopic examination was performed by George Kelling in 1901, a surgeon of Dresden, Germany. He inserted a cystoscope into the adbominal cavity of a dog and visualized the abdominal organs. Jacobeus of Sweden was the first to apply it in patients in 1910, and called it laparoscopy. In the United States, laparoscopy was first used in 1911 by Bernheim, and it was not until the late 1930's, that this type of endoscopy became popular. Ruddock, an internist and main proponent of the procedure in the U.S., reported 500 cases in 1937. He performed the procedure under local anesthesia to investigate the upper abdominal pathology. In the same year, Hope emphasized the great value of laparoscopy in the differential diagnosis of ectopic pregnancy, and Anderson performed the first tubal sterilization by endothermic coagulation of the tubes. Palmer improved the technique of laparoscopy in 1941 and urged the use of the intra-uterine patency cannula. In 1950, with the development of fiber optics, the improved light source allowed for better visualization and photography of the pelvic cavity. Stepto, in 1966, described the cauterization of the tubes at two points and then dividing it midway between the cauterized areas. In 1970, Cohen reported 50 cases of tubal sterilizations using modification of the Stepto technique which basically involved the coagulating, dividing and obtaining a piece of the cauterized tubes. At the present time laparoscopy is more popular then culdoscopy and efforts are being made to improve the techniques and instruments. Wheeless used the one incision technique for tubal sterilization in 1972 and he decreased the operating time to 15 minutes in 25 cases.

Material and Methods

General anesthesia is used. As previously reported from our department by Drs. L. G. Keith, N. Bozorgi, and R. S. Stepto, the anesthetic of choice is Ketamine. The patient is placed in a lithotomy position and prepped. The bladder is catheterized, pelvic examination is performed and intrauterine patency cannula is inserted. The abdomen is prepped and draped. Then pneumoperitoneum is created using Vere's needle and carbon dioxide gas with an average of 3-4 liters insufflated in abdominal cavity. The patient then is placed in Trendelenberg position at approximately 55 degrees. A small incision is made just below the umbilicus and a sharp trocar with a sleeve is inserted through this incision into the peritoneal cavity. The trochar is withdrawn and the telescope is inserted through the sleeve and the pelvic organs visualized. The uterus may be moved by

means of the cannula when needed. Another small incision is made midline between the symphasis and umbilicus (6 centimeters from the midline) and a trochar is introduced into the abdominal cavity. The trochar is then withdrawn and the Cohen-Eder biopsy tong is introduced into the sleeve. The biopsy tong is visualized through the telescope and the tubes are visualized. One tube in its full thickness is grasped at the midline and it is cut by screwing the outer cannula downward and applying cutting current. Then the biopsy tong is withdrawn and specimen saved for pathological examination. The same procedure is carried out on the other side. Then the cut ends of each tube are inspected for possible bleeding or incomplete cutting of the tubes. Then air is released from the abdomen and clips used to close the two incisions. The patient is usually discharged 24-48 hours after the procedure and clips removed before discharge.

Results

There were 239 cases of laparoscopy done at Mount Sinai Hospital Medical Center, Chicago, during the period of February, 1970 through June, 1972. Of these, 168 cases had tubal cautery and 71 cases had only laparoscopy for diagnosis. The age for tubal sterilization ranged from 19-42 years, with an average of 27.8; the average parity was four. The indications for tubal sterilization was multiparity, which accounted for 155 cases; 12 for hypertension; and one because of mental retardation. Fourteen patients who had tubal sterilization were two days postpartum and two patients had intrauterine device in the abdominal cavity removed through the laparoscope, before sterilization. Attending physicians did 123 cases; 116 were done by the resident staff. The average time consumed was 32 minutes. There were no complications except bleeding after cutting and laparotomy was performed in six cases. There was only one pregnancy reported up to this date. There were 71 diagnostic laparoscopies. One failed because of extreme obesity and 17 had laparotomy for therapy as shown in Table 1. There was only one complication from laparoscopy which was immediate severe bleeding after attempting to do biopsy of the ovary. Laparotomy was avoided in 53 cases. Indication for laparoscopy are summarized in Table 2, and post-operative diagnosis tabulated in Table 3.

TABLE 1

Diagnosis	Number	Treatment
Ectopic Pregnancy	5	Salpingectomy
Ovarian Cyst	2	Salpingo-oophorectomy
Stein-Leventhal Ovaries	4	Wedge resection of both ovaries
Chronic PID with Hydrosalphinx	2	Total abdominal hysterectomy w/bilateral salpingo-oophorectomy
Occluded Fallopian Tubes	2	Tuboplasty
Appendicitis (Acute)	1	Appendectomy
TOTAL	17	

Comments

Laparoscopy is a simple procedure and is even performed in many medical centers as an outpatient procedure. However, it should be emphasized that there are inherent dangers in the use of the laparoscope. Serious complications, although few in number, can occur, as reported in the literature, such as perforation of the visceral organs, puncture of large vessels in the abdominal wall, rupture of the diaphragm, gas embolism, pneumothorax, cardiac respiratory arrest, burns, and severe bleeding in cases of tubal cautery.

Indeed, it is extremely important that the laparoscopist is well trained not only in the use of the laparoscope but also should know the details of the whole instrument, including the correct use of the cautery and the hazards that may occur. Sometimes, a simple ignorance of

TABLE 2

Indications & Pre-Operative Diagnosis	Number
Obscure Pelvic Pathology	13
Infertility	18
Pelvic Mass	21
Ectopic Pregnancy	16
Stein-Leventhal Syndrome	3
TOTAL	71

ASUNCION IMPERIAL-HIZON, M.D., an obstetrican/gynecalagist, has done past graduate study in infertilitiy and endocrinalogy. She is a member of the American College af Loporascopists and a Fellow in the Americon Fertility and Sterility Saciety and American College af Obstetrics/Gynecology. Dr. Hizon is a medicol cansultant to the Family Planning Clinic at Mt. Sinai Hospital, Chicago. ROBERT C. STEPTO, M.D., Ph.D., is Chairman, Department af Obstetrics/Gynecalagy at Chicago Medicol School, Cook Caunty and Mt. Sinai Hospitals, Chicogo.

TABLE 3

Post-Operative Findings	Number
Ectopic Pregnancy	5
Polycystic Ovary	6
Leiomyoma	7
Small Ovarian Cyst	6
Solid Ovarian Tumor	2
Endometriosis	8
Intrauterine Pregnancy	3
Pelvic Inflammatory Disease	19
Hydrosalphinx w/Tubal Occlusions	9
Normal Pelvic Organs	8
Peritoneal Granuloma	2
Appendicitis	1
TOTAL	76

not knowing the instrument can cause problems. A sheath to sheath contact of the laparoscope and the biopsy tong can produce a spark that can burn the intestine or any viscera. Furthermore, if extreme care is ignored, even an experienced laparoscopist can perforate a large blood vessel in the abdomen. These complications are real and should not discourage the gynecologist, but instead bear in mind these complications. It is clear in our study that laparoscopy is a very valuable factor in the diagnosis of obscure pelvic pathology and infertility. However, as a tool for tubal sterilization, the success rates are comparable to the classical abdominal tubal ligation by Pomeroys method.

In our study of 168 cases of tubal sterilization by laparascopy, we had only one known pregnancy to date, a failure rate of 0.5%. Our complications are negligible and minor, which occur only in six patients and five are due to bleeding after cautery and cutting the tubes with biopsy forcep. The other complication was a perforation of the uterus from the trochar and was a second day postpartum uterus. Tubal cauterizations postpartum were done to familiarize and teach the residents in the use of the laparoscope. However, this was discontinued when one uterus was perforated and it was also deemed impractical because of the time consumed to do it, compared to the classical small incision postpartum. Of the 14 cases of tubal cauterizations done two days postpartum, there was no significant bleeding obtained and the postoperative course was satisfactory.

Conclusion

It is our impression that the laparoscope is a very useful instrument for a gynecologist, but it can be a double edged weapon in view of the grave complications that can occur in its use. It is, therefore, mandatory that only trained laparoscopists should perform tubal sterilization with well trained assistants and nurses, and the case also should be carefully selected. It must be emphasized also that only carbon dioxide gas should be used because it is rapidly dissolved in the blood and it is blown off by the lungs very rapidly. Nitrous oxide should not be used because it is relatively insoluble in the blood and hence may cause air embolism, and also the gas is combustible. However, nitrous oxide gas does not cause significant increase in PCO_2, unlike carbon dioxide gas. For this reason cardiac arrythmia is seen more on carbon dioxide insufflation and this was attributed to the increase in PCO_2 and also due to the reflex activity initiated by a distended abdomen and diaphragm. Hypotension can also occur during the pneumo-peritoneum, but the cause of the drop in blood pressure is not yet known, although they believe it is due to vagal reflex, or to the decrease in venous return. It is therefore necessary that the anesthesiologist should be part of a team in laparoscopy, who is aware of these factors and that the blood pressure, ECG, and heart sounds should be watched constantly during the procedure. With the advances in the technique, modifications of the instruments to improve use, and extensive training of more gynecologist to be laparoscopists will lessen the complications of laparoscopy. ◄

References

A complete bibliography for the Impact of Laparoscopy in the Community Hospital may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe St., Suite 3510, Chicago 60603.

ISMS New Headquarters

In February, 1975, the Illinois State Medical Society office will move to 55 E. Monroe St., Suite 3510, Chicago, 60603. The phone number will remain the same.

House at this new address include the staffs of the *Illinois Medical Journal,* Illinois Foundation For Medical Care, Illinois Council on Continuing Medical Education, Illinois Psychiatric Society, Illinois Society of Internal Medicine, and Illinois Ophthalmology Association.

The Health Care Team In Private Practice

By Fred Z. White, M.D., Judy Koch, R.N. and Melba Jury, R.N./Peoria

The Health Care Team has been the subject of a great deal of recent discussion. Many health care planners seem to favor this team concept as the best vehicle for the delivery of primary health care. Proponents of the team concept are easily found in the four major groups involved in primary care, i.e. the consumers, providers, educators, and the fiscal agents. There is apparent agreement among these groups that multi-disciplinary teams of health professionals will function together to deliver primary health care in a manner that is better than that delivered by the traditional provider of primary health care, i.e. the solo or small group private practitioner. From this continuing discussion one must assume that the team concept of health care is under consideration as the potential replacement for our present providers.

Before accepting the health care team as an improved method of care, it would seem prudent to test the concept in realistic and practical settings. If the concept is indeed a viable alternative, then it should function as well for the smaller community practice and the population that the practice serves. This is important since the health care teams frequently described are those found in neighborhood health centers, large group practices, or other larger population density settings. Any beneficial function ascribed to such teams must be equally valid in rural and community practices. The effectiveness and outcomes of these health care teams should be measurable. Only then can comparisons be made with the present methods of health delivery. With such comparative data in hand, we can then begin to make judgments on the future of health care teams as a practical alternative to the traditional physician in office practice.

The purpose of this study is to test the hypothesis that a health care team can be developed from existing personnel in an actual rural office practice setting, and that a team so constituted would deliver health care to the usual patient population served by that office in an improved manner. Implicit in this hypothesis is the requirement that the quality of care delivered would be as good or better; that the cost would be the same or less; and that patient acceptance would be satisfactory.

FRED Z. WHITE, M.D., is Director of Graduate Education for Family Practice at Peoria School of Medicine. An ISMS Trustee, Dr. White serves on numerous councils and committees and is a Diplomate of the American Board of Family Practice.

Setting

The office utilized in this study is in a semi-rural community in Central Illinois with a population of approximately 6,000. The staff of this office is composed of two family physicians, two R.N.'s, a medical technologist and five office assistants. For the purpose of this study, this staff of available professionals and para-professionals constituted the raw material from which the health care team was developed.

Team Development

An effectively functioning team has several basic routes of action that are almost universally applicable, regardless of the function of that team. These principles should be equally applicable to a baseball team and a health care team. Although these principles are quite basic and easily understood by most members of a sports team, they are worth spelling out when one is developing a team composed of health care professionals.

A team must function towards a common purpose or goal. In our case the goal is to deliver health care.

The team members must identify their problems and work out the responses to these problems. Each problem may require a different or shifting role for each team member. This then requires that individual identities, designations and roles, must be subjugated to the function to be performed. More than that, the individual roles and responses may change with each problem that is considered.

To begin the team process in this office setting, the office staff examined our practice to determine if there was a single significant problem on

which a team effort could be focused. Since it has become the intent of the family physician in this practice to render continuing comprehensive and preventive care to our patient population, much of the physician's time was programmed in doing periodic health assessments and physical examinations. These examinations were scheduled much ahead of time and most of the physician's available time was allocated to this effort. An additional segment of time was allocated to the discussion of our patient's individual and family problems. This resulted in almost an entire utilization of physician time in a programmed manner so that any unprogrammed additional load caused a strain on our system. The generic problem most likely to stress this system is that of epidemics of acute illness, which occur, of course, unscheduled.

Physicians in this practice when faced with such an epidemic were forced to decrease their comprehensive care functions to meet the peak loads imposed by intercurrent epidemics. The team recognized the problem created by such epidemics and selected the most commonly presenting acute problem, *the sore throat,* as the problem that the team would attempt to manage in this study. Given this as a specific presenting problem the diagnosis and management of *sore throat* was broken down into individual tasks and an algorithm and a protocol was developed. Then team members decided which of the identified tasks could be accomplished by each member of the health care team.

It must be recognized that from the standpoint of the health of the individual and the health of the community, the critical medical problem involved in the management of sore throat, is that of stretococcal pharyngitis. The following algorithm was then developed with the diagnostic and treatment protocol. The team members who could perform each task were designated (Protocol—#1).

Method

The patient presenting with a sore throat was seen by the office nurse associate who performed an initial evaluation of the patient and his/her problem. This evaluation included a history of the present illness and a physical assessment. Problems or findings that were identified as being outside of the established protocol, e.g. penicillin allergy—otitis media—etc., were then referred to the M.D. team member. If nothing outside of the protocol was found a throat swab was performed and if the patient's symptoms seemed severe, palliative medication (a specified analgesic and or decongestant combination) was prescribed. The throat culture was plated on blood sugar agar under carbon dioxide and incubated for 24 hours. If the culture was positive, the second step in the protocol was followed and the patient was treated appropriately and all other family members were brought in for throat cultures. In all cases the purpose of this was explained to the family and an explanatory handout was given to the patient and family.

A fee for this evaluation by the nurse of $5 and a fee for the throat culture of $2 was charged. There was no charge made for a "test of cure" cultures. "Test of cure" cultures and cultures performed on asymptomatic family members (where no evaluation was required) were usually performed by the medical technologist.

Working with this protocol, it can be seen from the task designation that the physician rarely needed to be involved in the diagnosis, treatment or management of the presenting problem of *sore throat.* If at any time the patient questioned the protocol, the services of the other professionals, or stated that he would rather see the doctor, that patient was immediately referred to the doctor. This, however, occurred only on very few occasions.

Using this protocol, 1,753 patients were managed by members of the team. The nurse associates and medical technologist really managed this number of patients with very little active participation by either of the family physicians. The major involvement of the physicians in this team effort was in the development of the protocol. Once the team began to function, the physicians served as the first line of consultation and as monitors for quality control.

Data

The data generated in this study revealed that 1,194 patients presented with the problem of *sore throat* of which 199 had positive throat cultures. These patients were all treated with a 10 day course of oral penicillin or an injection of Benzathine Penicillin G. 600,000 units. Family members of the patients with positive cultures were asked to come into the office for throat cultures. Of these family members that were cultured, 52 were found to be carriers and appropriately treated. These 52 were all asymptomatic carriers of strepotococcal disease. It should be noted that a follow-up culture was always requested following the 10 days of treatment. Over 60% of the patients with positive cultures did return for a "test of cure" culture. Those that did not return

were called and reminded that they should come in for this "test of cure" culture. Of the 151 patients that were cultured after 10 days of treatment, 9.27% were found to have persistently positive cultures by the method used in this study.

Given a persistently positive culture after 10 days of treatment, a decision was made as to the compliance of the patient with the course of treatment; if there was any doubt of total compliance, Benzathine Penicillin G. 600,000 units was administered and the patient was again recultured in 10 days. This was done to be absolutely certain that proper medication over sufficient period of time had been utilized in treatment of the streptococcal pharyngitis.

Seven patients were found to have a persistently positive throat culture where it was quite certain that adequate treatment had been rendered (4.63%). In these few instances these patients were referred to the hospital laboratory for a culture and sensitivity study. The laboratory studies in these cases indicated the organism was not a beta hemolytic strep and represented a failure in our "less-than-perfect" office culture method. The lessened cost of the office culture method, even though "less-than-perfect," seemed to justify this small failure rate in our testing procedure.

Evaluation

It is apparent from this study that a team can be developed from the existing personnel in an active practice and that this team can meet the diagnostic and management needs of a given problem. The team approach to this given problem can be evaluated and measured against the traditional method by varied criteria. Among these factors that can be measured are: (1) quality, (2) patient acceptance, and (3) cost to the patient population of the care rendered.

From the data accumulated it is apparent that the quality of care rendered by our team was as good as that offered by the same office under the previous traditional methods.

Assessment of patient acceptance is subjective and difficult to quantitate. However, the feedback to all office personnel would indicate that our patient population appreciated the thoroughness of the protocol and follow-up and the more ready and rapid access to treatment when this team approach was utilized.

In evaluating the cost effectiveness of the team a comparison between actual costs of the team and traditional costs was made. Since more than one approach to the presenting problem of *sore throat* is possible, several alternatives, all within the traditional physician model, were projected for comparison.

Under the team method, as previously stated, the nurse evaluated all presenting with *sore throat*. The fee for this evaluation was $5. All initial throat cultures on those patients presenting with *sore throat* as well as asymptomatic family members were charged a fee of $2. The cost then, as actually made under this protocol was:

1,194 patients evaluated for sore throat at $5 each	$ 5,970
1,194 throat cultures at $2 each	2,388
408 asymptomatic family members throat cultures at $2 each	816
Total cost to patient population	$ 9,174

Under the traditional model the M.D. would make the initial assessment at a fee of $6.00, and the same $2.00 fee for cultures. The following costs would be generated:

1,194 presenting sore throats at $6	$ 7,164
1,194 symptomatic throat cultures at $2	2,388
408 asymptomatic throat cultures at $2	816
Total cost to patient population	$10,368

The only difference in the traditional model using this approach then would be that the physician functioned in the same role as the nurse did within the team. This would result in a cost to the patient population of $1,194 in excess of the team model. The significant cost here is the additional loss of time for the physician that could be better spent in a more productive manner in other areas or in other efforts.

Another possible alternative under the traditional model would be for the physician to charge for each patient encountered i.e. the symptomatic sore throat and all family members. Then the following costs would be generated:

1,602 encounters at $6	$ 9,612
1,602 throat cultures at $2	3,204
Total cost to patient population	$12,816

Under this possible method within the traditional model this cost would be $3,642 over the actual team cost.

There were actually 1,753 patient encounters. This includes "test of cure" throat cultures, asymptomatic family members, and those presenting with *sore throat*. In the traditional model "fee-for-service" practice situation another alternative might be that almost all of these encounters would involve the physician. Therefore, a fee for that service or consultation might have been made, generating the following costs:

1,753 patient encounters at $6	$10,518
1,753 throat cultures at $2	3,506
Total cost to patient population	$14,024

Excess cost of this method over the team actual cost is $4,850. It can be seen from this comparative study that the team approach to this problem did result in savings to the community ranging from $1,194 to $4,850.

EXPERIENCE FOR 8 MONTHS

Patients Presenting With "Sore Throat"	1194		
Positive Cultures		199	16.66%
Family Members Cultures (Asymptomatic)	408		
Positive Cultures (Asymptomatic Family Members)		52	12.74%
Total Cultures	1602		
Total Positive Cultures		251	
Overall Percentage of Positive Cultures			15.67%
Test of Cure Cultures		151	
Positive Test of Cure Cultures		14	9.27%
Positive After Compliance		7	4.63%
Total Throat Cultures Performed		1753	
Actual Patient Encounters		1753	

PROTOCOL FOR PRESENTING PROBLEM OF *SORE THROAT*

A. Initial Visit
 1. History and Physical Assessment
 2. Palliative Rx if Needed
 3. Throat Culture

B. Culture Negative - No Additional Rx

C. Positive Culture
 1. Rx with Benzathine Penicillin G. 600,000 Units or Oral Penicillin 400,000 Units TID x 10 Days
 2. Call in all family members and contacts for throat cultures.
 3. Patient education, explanation, and handout material.
 4. Instruct all positives to return in 10 days for "test of cure" culture.

D. Asymptomatic Contacts with Negative Cultures - No Rx

E. Asymptomatic Contacts with Positive Cultures
 1. Follow protocol for positive cultures as in C (above)

F. "Test of Cure" Culture
 1. Negative Culture - No Rx - Dismiss
 2. Positive culture with compliance in doubt
 a. Benzathine Penicillin G. 600,000 Units
 b. Return in 10 days for repeat "test of cure" culture
 3. Positive culture with compliance or after Benzathine Penicillin G.
 a. Throat culture to hospital laboratory for culture and sensitivity

Discussion

From the data generated in this study a number of conclusions can be drawn and several additional suppositions can be made.

By addressing themselve to a single problem in health care, a team composed of already functioning professionals within a practice setting can appropriately divide the diagnosis, treatment, and management of the problem into simple tasks. The team can then decide which of its members can appropriately perform the particular designated task. With the algorithm and protocol thus developed, the problem can be appropriately and efficiently managed by the health care tem.

In this study, it was found that the physician was not necessary to the diagnosis, treatment, or management of the presenting problem of *sore throat,* except in very rare occasions. The total management of this problem, therefore, was handled by other members of the team. The physician was then free to pursue the continuing health management of the families under his care. In the opinion of these writers, that is an appropriate utilization of the physician's skills, talents, and time. Expending physician time in performing tasks that others could do equally well is an inappropriate utilization of these skills and talents.

The nurse associates felt that their knowledge and skill was more appropriately utilized as they managed this problem via our protocol. The sense of involvement in judgment and decision-making, even though these judgments were within protocol limitations, contributed to a feeling of career fulfillment that was not present in the previous traditional model of care. All team members agree that this is a positive motivating force in our delivery of care.

The significant number of asymptomatic positive throat cultures for beta hemolytic strep that were identified and treated through the use of this protocol, indicates that this health care team

HEALTH TEAM REQUIREMENTS

Tasks	Performed By *M.D.*	*Nurse*	*Med. Tech.*
A. Inital Visit	±	±	—
C. Rx for Positive Cultures	±	±	—
D. Asymptomatic Contacts	±	±	±
E. Rx Asymptomatic Positive Cultures	±	±	—
F. "Test of Cure" Culture	±	±	±
F.[2] Positive "Test of Cure"	±	±	±

Key to Task Performances:
+ Must Perform
— Cannot Perform
± Optional Performance

did indeed have an impact on the health of the community. Through their management of this problem, one must assume that the health of the community was improved through the prevention of carrier states and additional exposures to beta hemolytic streptococci. This could be projected empirically to mean that this team through its management of this problem aided in the prevention of rheumatic fever in the community. This speaks further to the quality of care rendered by the team.

From a cost standpoint the team approach is less expensive to the community than the traditional approach. The additional saving of physician time through more appropriate utilization is not measurable in dollars, but is a significant plus factor.

The inescapable conclusion drawn from this study is that a health care team can appropriately function in rural and small group practice settings. The team can be developed from existing health care personnel without the addition of specifically or specially trained individuals. A team so constituted can identify problems and develop the protocol needed to meet that problem. In order to do this they must understand and be able to work with the principles of team function. This study has demonstrated the approach of an actual team in a practical situation in the management of a single problem. It is obvious that the same approach is feasible in meeting other problems and other health care needs.

This study suggests the benefits to be gained from a team approach to a problem in a private practice. Benefits from this approach will accrue to all of the individuals and groups involved in the management of the problem. The total cost of care to the individual, the family, and the community will be less. The quality of care rendered and the outcome of that care is equally good. The patient acceptance from this mode of care is good. The nurse associates develop a feeling of greater self-worth that makes their continuation in their career more meaningful. The physician has more time to devote to other efforts more appropriate to his skills and talents. Because the physician will have input in these management processes through development of the protocol and algorithm and by monitoring the care rendered, he will not abrogate his patient responsibilities. The obvious advantage to the physician is that he can more appropriately utilize his skill and time; without loss of income, while maintaining quality control.

The final conclusion is equally inescapable and that is that the utilization of the health care team is feasible and practical in a private practice setting. Such a team will economically yield good quality care to the practice population and the efforts of that team will have an impact on the health of the community as well as on the health of the individuals they serve. ◄

General Hospital ER Psychiatry

(Continued from page 41)

Persons who are unmarried, unemployed, and who have a past history of psychiatric hospitalization are markedly over-represented in the group of persons seen in consultation by the psychiatric resident. One half of the persons seen by the psychiatric resident originally perceived their problem in medical or physiological terms. A certain number of persons have their emotional crisis managed through costly medical diagnostic procedures. Diagnostic categories of persons coming to the emergency room are tabulated. Some implications for service design are drawn from the data presented.

Acknowledgement

The authors wish to thank Dr. Norris Hansell, Associate Professor of Phychiatry and Dr. Harold Visotsky, Chairman, Department of Psychiatry, Northwestern University School of Medicine, for their help and encouragement in the preparation of this paper. ◄

Obituaries

*Bayar, Cem, Evanston, died Sept. 28, at the age of 54. He graduated from Istanbul University in 1949.

*Elliott, Frank, Glencoe, died Nov. 2, at the age of 61. He graduated from Northwestern University Medical School in 1940. Dr. Elliott was a staff member of the Passavant Pavillion of Northwestern Memorial Hospital.

**Sellards, Abrahm, Joliet, died Dec. 11, at the age of 82. He graduated from the Chicago College of Medicine in 1917. Dr. Sellard practiced medicine in Joliet for over 50 years.

*Sours, James, Peoria, died Nov. 15, at the age of 69. He graduated from Northwestern University Medical School in 1928. Dr. Sours was a retired member of the Peoria Medical Society and also was a member of the American College of Physicains.

**Traisman, Alfred, Chicago, died Dec. 7, at the age of 78. He graduated from the University of Illinois in 1923. Dr. Traisman was on the staff at Children's Memorial Hospital and an associate professor emeritus at the Northwestern University Medical School.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

"Rockford Revisited"

By John Williamson, M.D./Baltimore, Md.

Last year's Congress focused on "How to Identify Needs in CME"; a unique feature was a final wrap-up summarizing the day's activities rather than the usual keynote address. Space limitations necessitate printing only a condensation of that speech; the full Report of the 1974 Congress may be had upon request to: ICCME, Suite 3510, 55 East Monroe, Chicago 60603 (FREE to Illinois physicians, M.D. or D.O.; $1/copy to all others.)

Identifying physician learning needs is a problem that begins to be solved when people recognize that making CME topics and subject areas more explicit, and then arraying them in some order of priority, facilitates educational effort. I became involved with continuing medical education during a two-year fellowship in infectious disease at the University of California; the topic proved so interesting that it has become a major focus for me. My first formal work in the field was a three-year experience at the University of Illinois College of Medicine several years ago. One of the first projects organized required an institution for work in developing methods of diagnosing educational needs of practicing physicians; the first institution to step forward was Rockford Memorial Hospital.

A study was developed to test whether looking at one specific area, identifying a problem, and trying to correct its causes, one could see if continuing education makes a difference. The paper titled "Continuing Education and Patient Care Research"[1]—the Rockford Study—was the result of this first effort. Next came a series of studies on methods for establishing priorities by identifying what problems were most prevalent and what problems were causing the most preventable impairment in terms of patient outcomes.

A second area also was identified that has marked my work since—trying to measure patient outcomes in terms of health, from which we could identify patient-care problems and provide focused learning needs. We were trying to learn *"who* needs to learn *what* in order to most improve patient outcomes in a given population."

These essential studies have been carried on in some 23 clinics and hospitals around the country, ranging from the Boston area to Los Angeles, and involving some 57 outcome-based projects. In this effort a variety of methods for identifying learning needs have been tried.

All of this started at Rockford. It may be difficult to fully appreciate the courage of the staff at the Rockford Memorial Hospital. They permitted investigators to examine what they were doing, and possibly expose the results in the medical literature. Even now there are medical staffs afraid to participate in such studies, for fear that findings might have adverse effects. This is one of the first problems to be faced: it is possible that some bad things might be uncovered, along with good things. In terms of "Rockford Revisited," good things have outweighed the bad—progress made technolgically and work done since (including possible influence in the development of the new medical school) is a tribute to the Rockford group of physicians who were willing to participate in CME studies at that early time.

Reactions to Methods Workshops

Here are my reactions to the five methods for needs-identification that have been the foci of the 1974 Congress effort.

Self-Assessment

This is a superb method for getting the individual physician personally involved, as he

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Editor's note: This summary of the 1974 Illinois Congress on CME appears as invitations for the 1975 Congress, which is scheduled for April 18-19, 1975, at Chateau Louise, in Dundee, are being sent out.

tries to take a look at what he knows in relation to self-assessment instruments available. The convenience of this method in *time, place,* and *content* also is an advantage. Self-Assessment further offers a definitive educational diagnostic tool that focuses on the cognitive domain—factual learning and factual knowledge of any particular problem; this is perhaps its major strength.

On the negative side, this method is inadequate for providing any *comprehensive* initial overview of learning needs. It has a narrow content scope; the fact that it is mainly limited to cognitive learning means that it excludes motor skills and all of the affective problems of attitudes and values and interests. Further, it often stresses organic medical problems—a rather narrow area. Finally, some evidence is accumulating to substantiate that this method may not predict future behavioral competence.

Individual Physician Profile

The Individual Physician Profile offers opportunity to relate each physician's CME to his total practice pattern. It thus focuses attention on individual patients. The IPP enables the practitioner to recognize patterns by analysis of the total group of people that he sees.

This method has the definite advantage of *personal involvement.* The physician is looking at his own practice pattern; the data from this type of tabulation have multiple applications, often revealing some surprises. There may be reason, however, to question the validity of this type of log, where one records each patient contact for a limited period, whether the sampling is a valid representation of what one sees in practice.

The disadvantage of this method is that it might overemphasize problem prevalence, to the exclusion of important problems that may be less common. For example, some low-prevalence conditions may have an important impact due to the impairment they cause; a large number of preventable deaths may be involved in a small number of cases. It also is important to consider the problems of preventable disability as another factor to put into the equation. Problem prevalence is certainly the first step—but if one stops there, serious omissions may occur.

A second drawback to the IPP stems from the limitations of ICDA code categories, which are oriented to hospital patients with organic disease. A related problem must also be raised: There seemed to be no mention of tabulation of patient *problems,* as opposed to *diagnoses.* To assess diagnostic performance one has to start with problems. Diagnoses facilitate assessment of therapeutic performance—but data based on diagnoses often fails to reveal "false negatives," *i.e.,* patients who should have been diagnosed but were missed. Another point: the most meaningful way to get into examination of learning needs regarding ambulatory practice is to look at the problems as patients relate them to physicians.

The practice profile method does not seem to provide a comprehensive overview of areas most important for a further, more definitive look. It is a good first step, but several other factors need to be considered.

Interest Surveys

Surveys offer the definite advantage of physician involvement because you ask about individual interest, or at least subjective impression, and thus systematically make explicit the physician's expressed learning needs. Its major advantage is as a first step in introducing new problems, because it follows the principle of starting where the learner is, or trying to identify what he's doing or his interest.

One disadvantage is that it tends to focus on traditional CME methods. It does not provide a comprehensive overview—a problem in common with the other methods so far discussed.

Interpersonal Communication

In our studies, we have experienced several problems where this type of approach really broke a log jam. It is an excellent facilitator, it helps identify problems of *affect,* and it will sometimes provide breakthroughs in group activity when nothing else will.

As to disadvantages, the first is its limited scope. It requires a special receptivity to people, and deals with an affective level which is not appealing to many of those with whom you work. Unfortunately, the "hyper-rational" people are often those to whom this method would be most useful, but they are not going to sit still for any type on interaction on this basis. Secondly, it is time-consuming, and effectiveness may be limited to the amount of insight possessed by the facilitator. This particular approach is not suited to the comprehensive overview needed to identify major problem areas of all types—educational, administrative, affective or cognitive.

Hospital Practice Review

This classical method has a long history. The

major advantage is its practicality and efficiency in revealing some of the important *process* problems in hospital practice. The convenience that computerization offers cannot be questioned; it would be impossible to hand tabulate the analyses one can do with a computerized approach.

The well-thought-out, procedural approach shows the continued growth of this method. The system offered by the Commission on Professional and Hospital Activities, including training programs and consultation services, constitutes an important resource for the purpose of needs-identification.

The best feature of this method is conceptual: the idea of providing an approach by *successive approximation*. The CME planner may start out very broadly, narrowing down the problem-area successively as he determines need to proceed, so that at any point he can pull back or stop. Most other methods of needs-identification are all or none; one is usually committed to carry out the complete assessment study initially designed in order to draw any conclusion. This concept of successive approximation offers a major advantage in determining CME needs.

A serious limitation is that PAS limits us to a search for learning needs and problems "where the light is"—*i.e.*, to the in-hospital problems the data reveals. Many important in-patient organic problems are covered by the available data, and there are more data on those abstract forms than can be analyzed in 20 years. But still, even for in-patients, PAS data cannot address problems that require physician motor-sensory and affective skills, as well as important problems involving behavioral determinants, or educational, cultural, economic, and sociological factors that are not tabulated. Such variables may have considerable impact in improving health for many patients.

A second disadvantage, the two most important decisions for hospitalized patients take place in the physician's office, not in the hospital, initial work-up and decision for hospitalization; the end result as to health outcome related to the hospitalization, measured when the patient comes back to the physician's office for a check-up. Except for a small group for whom, while still in the hospital, it is possible to make an exact prediction—the greater number of patients will come back to the physician's office at a later time. In studies of surgical procedures[1] we found a shocking number of cholecystectomy patients who still had many of the same symptoms for which they had their gallbladder removed. Many problems appeared which we wouldn't have seen if we hadn't followed up patients in the physician's office after hospitalization.

Finally, hospital practice review is not suited for comprehensive initial assessment. For a comprehensive view, the ambulatory and hospital practice as parts of a single, continuous process must be considered jointly.

Further Needs-Identification Problems

There are several "basic science" fields in this area of learning that have not been mentioned, but to which one should be sensitive. The first and most important of these is the concept of *efficacy*—trying to show a factual basis for saying that a given medical intervention has any causal relationship to a health outcome, that it produces a given health benefit or causes specific harm. The next is *prognosis*—information that may be available on the natural history of conditions, *i.e.*, what happens to people who are not treated at all. Sometimes treated patients may not do as well as if they had received no treatment. Alvin Feinstein's work on prognosis is going to fill an important need.[2] He is able to identify prognostically similar hospital patients who have had different kinds of treatment for the same problems. In this way he is establishing which kinds and combinations of treatment seem to work best. This type of information is obviously needed for developing assessment standards. Another relevant "basic science area" is *epidemiology* and *health statistics*. The National Center for Health Statistics is an excellent resource for such information. Their National Ambulatory Medical Care Survey, especially, will provide some of the first national data related to physicians' office practice in ambulatory care.[3]

Another area that is important for identifying learning needs is *unit costing*—which relates to assessing the *efficiency* of medical practice. In this conference, learning needs related to medical *effectiveness* have been stressed primarily. Even if one will not concede that dollars are important, one must agree that efficient use of physician time is. Perhaps a little time in focused continuing education might save physicians a lot of time in patient practice; there is unquestioned need to consider how to learn to use time better and manage patient practice more efficiently. Finally, we need tools to provide means for *comprehensive screening* of medical practice, for identifying the most urgent learning needs.

This Congress is but one of a continuing series of efforts to help develop lasting skill in

CME planning. It's going to take a lot of trying, improving weak areas, and trying again. Seeing this Congress as one step in a continuing effort is important for achieving the maximum impact possible as we try to identify *who* needs to learn *what* to most improve patient care.

When effective CME methods are in routine use and having some effect, perhaps the development of a comprehensive approach will be achievable, one that will enable us to determine which, if any of these methods should be used at what time, for the greatest impact in improving patient health. There's no magic method available; much work is required to develop skills in identifying which method to use when. This might be one of the areas where an outcome approach to assessment of care would be most helpful.

Thirdly, the accumulation of needs-assessment basic science information and resources might be considered now. This has to be done on a state or national level, it cannot be expected of people in hospitals or local communities. One example might be the Edward Fries[4] studies on hypertension, which have established that anti-hypertensive medications are efficacious in prolonging life and preventing stroke, or the information from the National Center for Health Statistics, for example, indicating that there is no relationship between morbid events and the symptoms that hypertensive patients have. These are critical data regarding efficacy that would be helpful to those assessing physician learning needs in these particular problem areas. Such data are essential to provide a basis for assessment standards development. Feinstein's valuable work on prognostic data also is important in this regard. ◄

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Vitamin K Deficiency—Revisited

By Ruth Andrea Seeler, M.D./Chicago
Chairman, Pediatric Hemotology
Cook County Hospital and the Hektoen Institute of Medical Research

"Pediatric Perplexities" is a series of encounterable, but slightly uncommon, pediatric disorders which require prompt diagnosis and specific management for a good outcome. The editor welcomes suggestions for types of cases that the readers would like to have presented and discussed.

Medicine makes progress, conquers a disease, leaves it behind, and marches on—only to have the old problem often reappear in a new way. So it is with hemorrhagic disease of the newborn, due to vitamin K deficiency. In modern pediatric practice, it would be improper to speak of hemorrhagic disease of the newborn because the spectrum extends beyond the first days of life. Thus, I will review the hemorrhagic diathesis due to vitamin K deficiency as seen throughout early infancy.

In the 1940's, physicians were very conversant with hemorrhagic disease of the newborn, and its prevention or dramatic response to administration of vitamin K. Through the ensuing years, and concurrent with the development of microcoagulation techniques, it became obvious that the incidence of hemorrhagic disease varied considerably from nursery to nursery.[1] Currently, there is a flurry of reports of hemorrhagic phenomenon in older infants, with diarrheal disease of chronic malabsorption conditions, which are due to vitamin K deficiency.[2-9] Many of these infants have survived only through recent advances in synthetic formulas.

Let us begin by a brief review of the role of vitamin K in the coagulation scheme. Vitamin K is needed for the optimal synthesis of coagulation factors II, VII, IX, and X. Thus, in the deficient state, there is an abnormal prolongation of both the prothrombin time and the partial thromboplastin time.

Hemorrhagic Disease of the Newborn

Infants synthesize the vitamin K dependent coagulation factors using placentally transferred vitamin K. At birth the levels of the vitamin K dependent coagulation factors are depressed when compared to adult normal values, but not into hemorrhagic range. The circulating half life coagulation factors are measured in hours, and thus would be expected to decline if there was no further replenishment. Following birth, the infant is usually NPO for twelve hours, followed by sugar water feedings for the next twelve hours. Because of this, the prothrombin time becomes further prolonged and occasionally becomes sufficiently abnormal to result in hemorrhagic phenomenon.[10] In the normal neonate on the second day of life, the prothrombin time returns toward normal. This is because the neonate is now receiving formula and the bowel has become colonized with gram negative organisms which synthesize vitamin K. There is no fall of the vitamin K dependent coagulation factors when the infant receives 1 mg of vitamin K_1 (Mephyton, Aqua-Mephyton) at birth.[10]

By 1967 it was recognized that breast fed babies, who did not receive vitamin K, were the ones that exhibited this phenomena.[1] Infants fed cow's milk formula had normal coagulation, whether or not they received vitamin K. In fact, correction of the abnormal prothrombin time can be accomplished by the feeding of cow's milk formula.[1,10] As the normal neonate ingests only two, or, at most, three ounces at a feeding, the correction of the abnormal prothrombin time suggests that the physiological amount of vitamin K is extremely small. Current estimates indicate that the normal requirement of vitamin K is on the order of 50-100 micrograms per day.[4,11] Thus, the 1 mg (1,000 micrograms) dose of vitamin K conventionally given at birth is several hundred times the amount needed.

TABLE 1

Baby	BGW		DB		GP		CG	
Age	3 days		7 weeks		10 weeks		8 months	
Sex	F		M		F		F	
Hx	Normal newborn		Severe protracted diarrhea		Severe protracted diarrhea		Idiopathic cholestasis Pregestimil	
	No Vit. K		No pathogens Antibiotics Nutramigen		No pathogens No antibiotics Nutramigen		No antibiotics Bled from both ears Ecchymosis	
	Ecchymosis of left cheek		Day #20 Bleeding, GI, Needle punctures		Day #21 Epistaxis Hematemesis Hemathrosis Needle puncture sites		Jaundice Rickets	
		Post Rx		Post Rx		Post Rx		Post Px
PT (sec)	32.7	10.9	>120	13.9	100.3	12.9	>100	11.9
PTT (sec)	103.5	32.9	No Clot	40	>150 sec.	31.9	>100	27.4
II	1.5%	68%			<1%	80%		
VII & X (P&P)	<1.0%	66%			<1%	85%		
IX	3.5%	57%			<1%	100%		
V	140%	140%			100%	98%		

All infants had normal platelet counts, bleeding times, clot retraction, fibrinogen levels.

Why are breast fed infants particularly at risk of developing a hemorrhagic diathesis? Their first feedings are of colostrum, and further, human milk is relatively low in vitamin K when compared to cow's milk.[3,11] In addition, breast milk is sterile, and the gram negative colonization of the gastrointestinal tract in such infants is further delayed. In short, cow's milk formula babies do not need exogenous vitamin K, but breast fed babies do. I find it easier to give all infants 1 mg of vitamin K_1 than to remember those that specifically need it. There is no danger of an overdose with 1 mg, and when one considers the severe hemorrhagic phenomenon, including intracranial hemorrhage and death that can result from vitamin K deficiency, I prefer the routine of overcaution.[10,11]

Baby BGW (Table 1) is an example that hemorrhagic disease is still with us. The infant presented with an ecchymosis of the left cheek. Coagulation studies revealed a marked prolongation of both the PT and PTT. Following the administration of 1 mg of vitamin K, the PT and PTT rapidly returned to normal and the actual amounts of the vitamin K dependent factors rose into the normal range.

Maternal Anti-Convulsants

A special sub-group of full term infants with severe hemorrhagic disease due to vitamin K deficiency are those born to mothers with epilepsy taking hydantoin or barbiturate anti-convulsants.[12-16] In contrast to the usual hemorrhagic disease of the newborn seen on the 2nd or 3rd day, in these infants the hemorrhagic diathesis has been present at or within hours of birth, is unusually severe, and has resulted in a significant number of fatalities. The mothers of these infants uniformly have normal coagulation values.

The mechanism has been studied for diphenylhydantoin.[15] This drug crosses the placenta and exhibits a competitive inhibition with vitamin K which is similar to that of warfarin. In the infant, the diphenylhydantoin is eliminated very slowly and becomes concentrated in the liver. This, plus the depression of liver enzymatic activity characteristic of the fetus, would tend to make the drug far more toxic to the baby than the mother.

It is extremely important that infants born to women taking anticonvulsants receive vitamin K at birth. In unusual cases, further therapy including transfusion of blood, or factors II, VII, IX, and X concentrate, may be needed. Another alternative might be to administer vitamin K to the mother during the last weeks of pregnancy.[14]

Diarrhea

Throughout the first three, and possibly six, months of life, infants remain in a marginal vitamin K balance. The diet is not abundant in vitamin K and the vitamin is not stored to any appreciable extent. The levels of factors II, VII, IX and X are below adult normal values for three to six months.

Therefore an episode of acute gastroenteritis may result in a hemorrhagic diathesis for multiple reasons.[11] The infant is usually changed to a clear liquid solution so there is no vitamin K in the diet.[12] Antibiotics frequently are given, which reduce the normal gram negative flora of the bowel and their synthesis of vitamin K.[4] The rapid transit time further reduces absorption of the vitamin K and it is this factor which appears to be the most critical. If the diarrhea subsides promptly, any coagulation disturbance will return to normal even in a patient receiving antibiotics and a low vitamin K formula. However, in patients with protracted diarrhea, one can almost expect the patient to develop an abnormal coagulation profile.

DB and GP (Table 1) are illustrations of the severe degree of clinical hemorrhagic phenomenon and laboratory abnormalities seen in the hemorrhagic disease of vitamin K deficiency associated with diarrhea. In both of these infants they had a protracted, nonbacterial gastroenteritis. The clinical bleeding resulted in significant anemia in both children. Within one hour of the administration of 1 mg of vitamin K_1 the hemorrhagic phenomenon abated. Coagulation studies returned promptly to normal values.

Until recently, some of the formulas which were frequently used in diarrheal disease were particularly poor sources of vitamin K. At present, all manufacturers are following the recommendations of the American Academy of Pediatrics, and vitamin fortification of special infant formulas is now a fact.[11,17] Nevertheless, if an infant has a protracted diarrheal disease one should check the prothrombin time at least weekly. Infants on intravenous alimentation also will be prone to develop hemorrhagic disease due to vitamin K deficiency, if they do not receive vitamin K supplementation.

Chronic Malabsorption States

Children with a variety of disorders, having a chronic malabsorption component, are prone to develop a vitamin K deficient hemorrhagic diathesis. Such conditions include biliary atresia, cystic fibrosis, idiopathic cholestasis, prolonged intravenous alimentation (hyperalimentation).[8,9] These infants have a common fat malabsorption condition. As vitamin K is one of the fat soluble vitamins, such children are very prone to hemorrhagic diathesis. Our recent experience with a child with idiopathic cholestasis (CG) is illustrative of this phenomena.

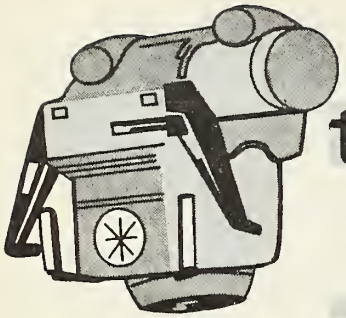
The patient was an 8-month-old female with idiopathic cholestasis. She presented with bleeding from both ears, was covered with ecchymosis, and jaundice and rickets reflected underlying liver disease. The PT and PTT were in excess of 100 seconds. Following the administration of 1 mg of vitamin K there was prompt cessation of the bleeding. The coagulation studies were totally normal when tested twelve hours later.

Therapy for Vitamin K Deficiency

There is no faster way to treat hemorrhagic diathesis due to vitamin K deficiency than giving vitamin K. Synthesis is extremely rapid, and cessation of hemorrhage usually occurs within an hour or an hour and a half. Coagulation studies show marked improvement over the same time period, and are usually within the normal range four to six hours after administration of vitamin K. In the appropriate clinical situation, faced with the bleeding child, 1 mg of vitamin K would not be dangerous. If the hemorrhagic diathesis is due to vitamin K deficiency, one can expect very prompt cessation of the bleeding. If the patient has lost significant quantities of blood, transfusion may be necessary. In pure Vitamin K deficiency we have never found it necessary to resort to the infusion of factors II, VII, IX, and X concentrate. The prompt cessation of hemorrhage following vitamin K administration has been sufficient.

As a general rule, young infants, especially those breast fed, who are to undergo elective diagnostic or surgical procedures, should either have a prothrombin time done or 1 mg of vitamin K the night before surgery. Severe life threatening hemorrhage has been recorded in otherwise healthy infants undergoing relatively minor surgical procedures.[6] The author acknowledges, as a practical matter, that it is far easier to give a breast fed baby 1 mg of vitamin K before an elective surgical procedure than it is to obtain the blood, do a prothrombin time, and then, if it is abnormal, have to repeat it after giving vitamin K.

(Continued on page 82)



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

A 39-year-old male complained of abdominal pain and a weight loss of 10 pounds, diarrhea, but no evidence of blood in the stools.



FIGURE 1



FIGURE 2

1. Granulomatous disease of the colon
2. Ulcerative colitis
3. Linitis plastica of the colon
4. Lymphoma
5. Segmental infarction

What's your diagnosis? (Answer on page 82)

Recent Trends of Blood Usage in a Suburban General Hospital

By Takashi Okuno, M.D., and Arlene Nelson, B.S., MT (ASCP)/Park Ridge

Public interest in blood banking has greatly increased in recent years. A great publicity has been given to the few blood banks of marginal operation. National volunteer blood donor programs have been seriously discussed. This upsurge of the recent public interest can be attributed to a series of recent developments. They are the discovery of hepatitis associated antigen and its wide application in blood banking, the increasing demand for blood and its components, steady campaigns for safe blood and recent medicolegal rulings.

One of such medicolegal rulings took place in October, 1970, in Illinois, which has had national repercussions. In the Cunningham case, a hospital was held strictly liable to a patient who allegedly contracted hepatitis after a blood transfusion. The impact has been especially great on our hospital, a 675-bed general hospital in a suburb of Chicago, located within 20 miles of the hospital in which the case took place. It has been the feeling of those engaged in blood banking that, coinciding with these events, the trend of blood usage has changed in the last few years. In view of this, we analyzed the recent trend of blood usage in our hospital.



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ARLENE B. NELSON, BS, MT, (ASCP), SBB, is the Blood Bank Supervisor at Lutheran General Hospital, Park Ridge. She is a graduate of the University of Illinois and received her medical technology training at Copley Memorial Hospital, Aurora. She is past president of the Chicagoland Blood Bank Society.

Materials and Methods

Data were collected from the records of Lutheran General Hospital Blood Bank from 1960 through 1971. Pediatrics and nursery patients were excluded from this study. Charts of 341 patients who received single-unit blood transfusions during the period of 1969 through 1971 were reviewed. Some of the cases had been reviewed and analyzed by the Blood Transfusion Committee of the hospital. Clinical as well as laboratory changes of patients were considered for the basis of the criteria. They have been described previously.[1-5] Volume for volume replacement was not considered to be a necessary indication. In order to make the criteria as objective as possible, hematologic changes, especially hematocrit levels before and after transfusions, were carefully reviewed. Based on these analyses, the cases were divided into three groups: "necessary," "desirable," and "unnecessary" blood transfusion. Plasma, human albumin, platelets and fibrinogen, and cryoprecipitates were not included in this study.

TABLE 1

	1969	1970	1971
Whole Blood	1,369 (76.3%)	1,382 (69.5%)	1,021 (58.0%)
Packed Cells	425 (23.7%)	607 (30.5%)	740 (42.0%)
Total Units	1,794	1,989	1,761

Whole blood and packed cells in six units or less transfusions.

Results

Review of all patients who received single-unit transfusions in 1969, 1970, and 1971 is shown in Figure 1. Of these, 62%, were regarded as "necessary" transfusions in 1971. This was a substantial increase from 1970 or 1969, at which times only 49% of them were classified as "necessary." The increase was shown to be statistically significant ($x^2=4.12$; $p<0.05$). "Unnecessary" transfusions, on the other hand, showed a sharp decrease during 1971. The difference was significant ($x^2=4.64$; $p<0.05$). There was no significant difference between 1969 and 1970 ($x^2=0.75$; $p>0.30$). "Desirable" transfusions showed no significant changes during the period studied (22.0% in 1969; 15.9% in 1970; and 15.4% in 1971).

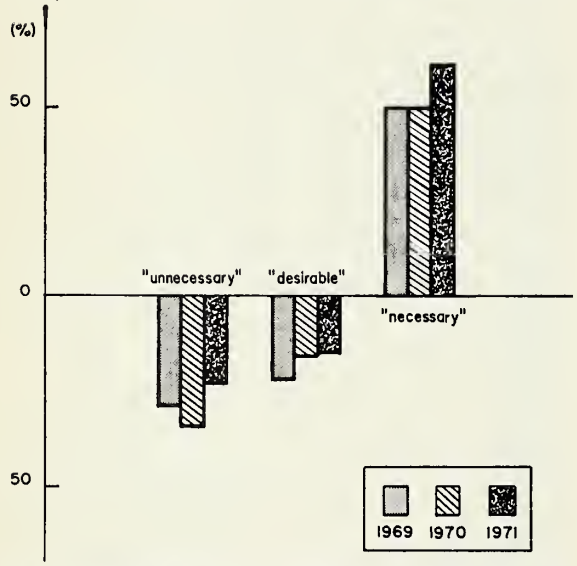


Fig. 1. Assessment of single-unit transfusions in 1969, 1970, and 1971.

A decline of single-unit transfusions for medical patients was noted in the last three years. Thus, only 8.6% of all single-unit transfusions were related to medical patients, while 91.4% of them were related to surgical or obstetrical procedures. In 1969, 21.9% of single-unit transfusions were administered to medical patients.

No single surgical procedure was found to be responsible for the decline of single-unit transfusions. Hysterectomy, hip fracture repairs, and urological surgeries were among the surgical procedures that required a good number of single-unit transfusions (Table 4).

The highest per cent of "necessary" transfusions was seen in hip fracture repairs, followed by urological surgeries, laminectomy, and mastectomy, while the highest per cent of "unnecessary" transfusions was observed in thoracotomy, followed by C-section and hysterectomy (Table 4).

Some surgical procedures required high percentages of blood transfusions and others needed large amount of blood units per patient (Table 3).

Review of Blood Utilization, 1960-1971

Packed cells: A substantial increase of the use of packed cells in the last few years was shown in Table 1. The increase was particularly prominent in 1971 when the number of blood units transfused was six units or less. The difference between 1970 and 1971 was significant ($x^2=5.26$; $p<0.025$), while the difference between 1969 and 1970 was not significant ($x^2=0.67$; $p>0.30$).

TABLE 2

	"Necessary" Transfusions	"Desirable" Transfusions	"Unnecessary" Transfusions	Single Units	Two Units	Packed Cells
1969 vs. 1970	*	*	*	*	*	*
1970 vs. 1971	$x^2=4.12$ $p<0.05$	*	$x^2=4.64$ $p<0.05$	*	*	$x^2=5.26$ $p<0.025$

***p value more than 0.05** **Statistical analysis of changes during the period of 1969 through 1971.**

TABLE 3

	Total Patients	Patients Transfused	Percentage of Patients Transfused	Total Number of Units Transfused	Average Units Per Patient
Bowel Resection & Gastrectomy	316	140	44.3	700	5.0
Laminectomy	133	51	38.4	215	4.2
Craniotomy	36	12	33.3	38	3.2
Hip Fracture Repair	319	96	30.1	297	3.1
Thoracotomy and Lobectomy	166	44	26.5	172	3.9
Hysterectomy	1103	160	14.5	387	2.4
C-Section	435	55	12.6	130	2.4
Urological Surgeries	2224	183	8.5	604	3.3
Mastectomy	849	64	7.9	115	1.8
D & C	2289	96	4.2	219	2.3
Cholecystectomy	838	33	3.9	100	3.0
Vaginal Delivery	5721	55	1.0	118	2.2

Blood usage in major surgical and obstetrical procedures in 1969, 1970, and 1971.

Single-unit transfusions: The use of single-unit transfusions shows a steady decline during the period of years studied, although no statistically significant difference between 1970 and 1971 was shown ($x^2=3.54$; $p>0.05$) (Fig. 2).

Two-unit transfusion: The use of two-unit transfusions steadily increased in the last seven years, with a rather sharp increase in the last three years. Statistically, no significant changes were seen (the increase from 1970 to 1971: $x^2=0.97$; $p>0.30$) (Fig. 2).

Others—"Use factor": Blood units per patient hospitalized was 0.162 in 1971.[6] This was a small decline from 1970 which had 0.167. Blood units per patient transfused were 3.903 units in 1971. This was a slight increase from 1970, when it was 3.793.

Discussion

Proper use of blood has been stressed in the past and many approaches to the problem have appeared in literature.[4,6,7] Evaluation of blood usage in hospitals has also been repeatedly emphasized.[5,8-10] Almost all studies have dealt with the necessity of educational programs for medical staff, establishing blood bank committees in hospitals, reviews of charts of single-unit transfusions or establishing a hepatitis follow-up system of patients who received blood. There were, however, very few reports delineating which factors played the most effective role in improving the blood usage, or the extent of the effects after implementing the proposed program. As a part of educational programs for the medical staff, we have regularly issued a news bulletin to inform

TABLE 4

	Patients Receiving Single Units	Patients Transfused	Percentage of Patients Receiving Single Units	Necessary (%)	Unnecessary (%)
Hip Fracture Repair	15	96	15.6	77.5	12.5
Urological Surgeries	42	183	13.7	68.0	16.0
Laminectomy	8	51	15.7	62.5	21.9
Mastectomy	24	64	37.5	60.0	25.0
D & C	24	96	25.0	53.3	33.0
Vaginal Delivery	12	55	25.6	38.5	33.5
Cholecystectomy	11	33	33.3	36.4	36.4
Bowel Resection and Gastrectomy	20	140	14.3	35.0	45.0
Craniotomy	2	12	16.7	33.3	33.3
Hysterectomy	42	160	26.3	28.6	38.8
C-Section	13	55	23.6	22.2	44.4
Thoracotomy and Lobectomy	17	44	38.6	12.5	56.2

Single-unit transfusions and their evaluation in common surgical and obstetrical procedures in 1969, 1970, and 1971.

them of recent topics in blood banking as well as proper blood usage in the past four years. In the end of 1969, a blood bank committee was established in our hospital to review single-unit transfusions. At the same time, a hepatitis follow-up system has been established. Despite these activities, no significant changes in trends of blood usage were demonstrated in 1970 (Table 2). The change of trends in 1971 coincided with a recent upsurge of public interests in blood banking, triggered by a series of developments

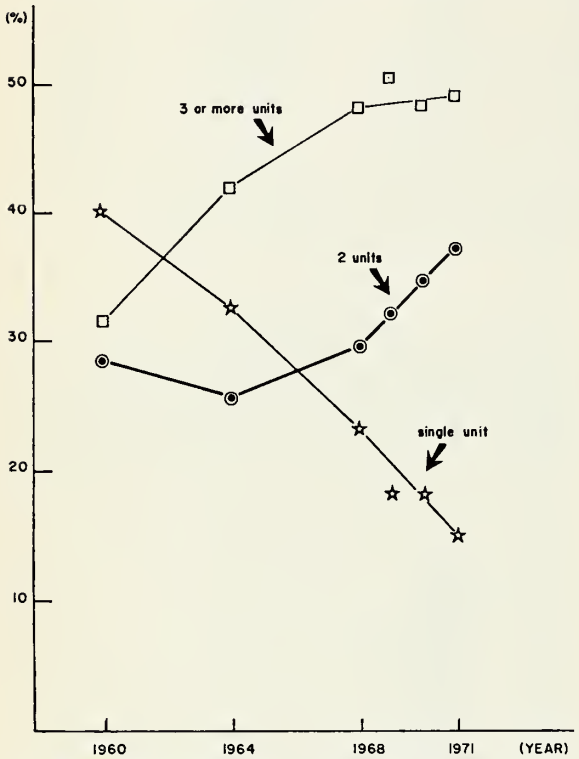


Fig. 2. Change of blood utilization during the period of 1960 through 1971.

Undoubtedly, a medicolegal ruling, which took place within 20 miles of our hospital, has had great impact in our hospital, perhaps greater than any other events (Table 2).

Use of single-unit transfusion has been critically analyzed in literature.[3,5,7] Except for some indicated cases, where single-unit transfusions are regarded as sound judgement, it has been repeatedly shown that there were a higher percentage of "unnecessary" transfusions in single-unit transfusions than in multiple transfusions. Diethrich reported that 25% of the multiple and 60% of the single-unit transfusions were not indicated.[3] Thus, it has been often mentioned that analysis of single-unit transfusions would give some indication of transfusion practice of a hospital. In our study, it was shown that 62.5% of them were justified in 1971. This was a sharp rise from 1969 or 1970, when it was little less than 50%. "Unnecessary" transfusions, on the other hand, showed a substantial decrease between 1970 and 1971, whereas, the changes between 1969 and 1970 were not significant. As has been pointed out before,[5] most of the cases of single-unit transfusions in this study were related to surgical procedures. It is interesting to note that there has been a gradual decline of single-unit transfusions for medical patients in the past three years. Single-unit transfusions were used regularly in specific surgical and obstetrical procedures (Table 4). No single procedure, however, was found to be responsible for the decline of single-unit transfusions in recent years.

The use of packed cells was a recent topic for discussion.[7,8] It has been mentioned that the use of packed cells possibly indicates relatively sophisticated medical management over all.[8] Our study showed a significant increase in packed cells in 1971.

This increase was especially significant when blood was transfused as six or less unit transfusions (Table 1). Although the figure of 42% of packed cells used in our hospital is not cause for pride,[11] a steady and substantial increase of packed cells indicated that more and more blood had been wisely used in the past few years. As expected, more packed cells were used in the multiple than in the single-unit transfusions in our study. Only 20% of the bloods were transfused as packed cells in single-unit transfusions, while it was 57% in six-unit transfusions.

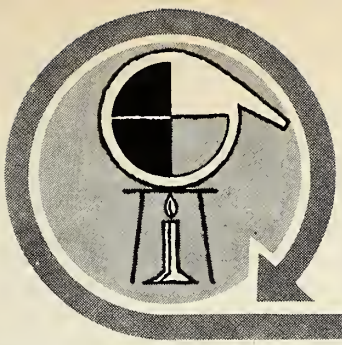
A general trend of a steady decline of single-unit transfusions was seen over the past 11 years, but this trend was not significantly affected in recent years. Interestingly, two-unit transfusions showed a gradual increase in the past seven years, indicating more and more blood has been transfused as two-unit or more transfusions instead of single-unit transfusions. This was in accordance with the recent increase in units transfused per patient.

Summary

The current trends of blood usage in a 675 bed suburban general hospital were analyzed by assessing single-unit transfusions and evaluating blood utilization including single-unit, two-unit, and packed red cell preparations. Significant changes in trends of blood usage were observed between the periods before and after 1971. The timing of these changes coincided with a recent upsurge of public interests in blood banking, notably after a medicolegal ruling in our community. ◄

References

A complete bibliography of Recent Trends of Blood Usage In A Suburban General Hospital may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.
Duplicate Single Products—Drugs marketed by more than one manufacturer.
Combination Products—Drugs consisting of two or more active ingredients.
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SINGLE CHEMICALS

ADRIAMYCIN — Cancer Chemotherapy Rx

Manufacturer:	Adria Laboratories, Inc.
Nonproprietary Name:	Doxorubicin HCl
Indications:	To produce regession in a variety of neoplastic conditions.
Precautions:	Use limited to specialists qualified to administer cytotoxic drugs.
Contraindications:	Patients who have myelosuppression induced by previous treatment; impaired cardiac function.
Dosage:	Follow instructions in package insert.
Supplied:	Vials, lyophilized powder 10 mg. and 50 mg. lactose. For intravenous use only.

CATAPRES — Hypotensive Rx

Manufacturer:	Boehringer Ingelheim, Ltd.
Nonproprietary Name:	Clonidine HCl
Indications:	Hypertension, may be combined with diuretic or other antihypertensive agents.
Warnings:	Tolerance may develop in some patients.
Precautions:	Cessation of therapy should be gradual.
Dosage:	Initial: 0.1 mg. twice daily Maintenance: Increase dose according patient's response.
Supplied:	Tablets; 0.1 and 0.2 mg.

MUTAMYCIN — Cancer Chemotherapy Rx

Manufacturer:	Bristol Laboratories
Nonproprietary Name:	Mitomycin
Indications:	Palliative treatment of various tumors and as adjunct to surgery or radiation.
Precautions:	Use limited to specialists qualified to administer cytotoxic drugs.
Contraindications:	Thrombocytopenia, coagulation disorders or increase in bleeding due to other causes.
Dosage:	Follow instructions in package insert.
Supplied:	Vials, 5 mg.

DUPLICATE SINGLE DRUGS

ANSPOR — Antibiotic Rx

Manufacturer:	Smith Kline & French Laboratories
Nonproprietary Name:	Cephradine
Indications:	Infections of the respiratory tract, ear, skin, and urinary tract caused by susceptible organisms.
Contraindications:	Hypersensitivity to cephalosporins; use with caution in patients susceptible to penicillins.
Dosage:	Follow instructions in package insert.
Supplied:	Capsules, 250 and 500 mg. Oral Suspension, 125 and 250 mg./5cc, reconstituted.

EXSEL Lotion — Dermatological Rx

Manufacturer:	G. S. Herbert Laboratories
Nonproprietary Name:	Selenium Sulfide
Indications:	Seborrheic dermatitis of the scalp.
Caution:	Keep away from eyes, use with caution in acute inflammation or exudation.
Administration:	Massage 1 or 2 tsp. into the wet scalp.
Supplied:	Plastic bottles, 4 fl. oz., 2.5%

LEMPROMETH — Antihistamine Rx

Manufacturer:	Lemmon Pharmacal Co.
Nonproprietary Name:	Promethazine HCl
Indications:	Allergic conditions of various etiologies. As an adjunct to analgesics. Therapy of motion sickness and nausea.
Precautions:	Patient should not drive car or operate machinery.
Dosage:	Allergic disorders; 12.5 mg before meals and at bedtime. Children ½ the dose. Other conditions; consult package insert.
Supplied:	Tablets, 25 and 50 mg.

LEMTREX — Broad and Medium Antibiotic Rx

Manufacturer:	Lemmon Pharmacal Co.
Nonproprietary Name:	Tetracycline HCl
Indications:	Variety of infections as described in the package insert.
Warnings:	Do not use during tooth development or renal impairment.
Dosage:	That usual for tetracycline
Supplied:	Capsules, 250 mg.

LEXXOR — Diuretic Rx

Manufacturer:	Lemmon Pharmacal Co.
Nonproprietary Name:	Hydrochlorothiazide
Indications:	Adjunctive therapy in edema with congestive heart failure, hepatic cirrhosis and corticos-

	teroid and estrogen therapy. Management of hypertension.
Contraindications:	Anuria
Precaution:	Use with caution in severe renal disease.
Dosage:	Edema, initially—25 to 200 mg. daily Maintenance—25 to 100 mg. daily. Hypertension, initially—75 mg. for first week Maintenance—adjust to patient's response.
Supplied:	Tablets, 50 mg.

OCUSERT PILO — Eye Preparation Rx

Manufacturer:	Alza Pharmaceuticals
Nonproprietary Name:	Pilocarpine
Indications:	Control of elevated intraocular pressure in pilocarpine responsive patients.
Contraindications:	Acute inflammatory disease of the anterior segment of the eye and postsurgical occurrence of glaucoma.
Dosage:	20 mcg/hr for one week, placed on the eye 40 mcg/hr for one week, placed on the eye
Supplied:	Ocular Therapeutic system, 5 and 11 mg.

VOJEL Cream — Dermatolgical o.t.c.

Manufacturer:	Wampole Laboratories
Nonproprietary Name:	Acetic acid in propylene glycol diacetate base.
Indications:	To restore and maintain protective acidity of the skin.
Administration:	Apply several times daily, especially after wet work.
Supplied:	Cream, tubes, 1 oz.

COMBINATION PRODUCTS

ACTOL Expectorant

Manufacturer:	Beecham Massengill Pharmaceuticals
Composition:	Noscapine 30 mg. Glyceryl Guaiacolate 200 mg.
Indications:	Cough therapy
Dosage:	Adults and children over 12 years of age, 1 tablet four times a day.
Supplied:	Tablets

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DECADERM in Estergel — Topical Corticosteroid Rx

Manufacturer:	Merck Sharp & Dohme
Nonproprietary Name:	Dexamethasone
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Vaccinia and Varicella infections, herpes simplex, fungal infections, tuberculosis of the skin.
Dosage:	Apply to affected area.
Supplied:	Tubes 15 and 30 Gm. 0.1% concentration. ◄

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Doctor's News

PLAN NOW TO ATTEND the ISMS Annual Meeting being held in conjunction with the Midwest Clinical Conference of the Chicago Medical Society, April 2-5, 1975. Site of the meeting is the McCormick Inn, 23rd and the Lake, Chicago, across from McCormick Place.

A highly diversified program of activities will be presented. Sessions of the policy-making ISMS House of Delegates will be held Wednesday, Friday and Saturday. A gala president's party is planned. Educational meetings will deal with health care delivery, socioeconomics, and important clinical topics. In addition, two special programs will relate to alcoholism and to the malpractice claims situation. A film program also will be included.

This important conclave brings the medical community together in a setting allowing free interchange of ideas, gathering of knowledge about clinical topics, and which encourages comraderie and fellowship. In addition, official activities determine the course medicine will follow as it addresses items affecting the practice of medicine.

For further information contact the ISMS Convention Manager, 360 North Michigan Ave., Chicago 60601 (312) 782-1654.

HCG DISCLAIMER ORDERED—Human Chorionic Gonadotropin, a hormone often promoted for use by weight reduction clinics, must bear a disclaimer stating that use is worthless as to accomplishing weight loss, according to a recent FDA ruling. Several Illinois clinics utilizing the preparation are currently under investigation by the Department of R&E. Acting on an Illinois resolution, the AMA House of Delegates recently concurred that HCG is not efficacious in this application.

ILLINOIS HEART ASSOCIATION has announced plans for its Annual Scientific Session, May 8-9, 1975, at the Holiday Inn East, Springfield. The program will be conducted in association with the Illinois Department of Public Health and will feature eight scientific papers.

BLOOD BANKING ORGANIZATIONS TO MERGE—The Cooperative Blood Replacement Program, Chicago, and the Metropolitan Chicago Blood Council, have taken necessary steps to accomplish a formal joining of the two agencies. The total metropolitan community will be served by the new group or the Mid-America Chapter of the Red Cross, which has not joined the new group. Goals of the organization are development of a coordinated blood donor system, an all-volunteer blood supply, provision of central services to hospitals and supplemental banks, and qualifying as a regional blood center under the National Blood Program of the American Blood Commission.

Through November, records of the MCBC indicate that of 190,562 units used in the metropolitan area, 171,519 (90%) was from volunteers. Recent citations in the press also report a study at Hines VA Hospital which indicates a decrease in hepatitis incidence since the inception of the Illinois blood labeling law. The new American Blood Commission will hold its first meeting in Washington, D.C., next March. This will establish the framework for development of the National Blood Program.

Of further note is that the minimum age for blood donors has been reduced to 17.

MALPRACTICE—Claims of malpractice in Cook County, based on suits filed through December, totaled 848, a 57.6% increase over the comparable 1973 period. This includes suits against non-MDs as well.

Since reports of incidents or claims against physicians from counties other than Cook are not received, the members are encouraged to monitor local situations and send any newsclips or data to the Medical-Legal Council of ISMS. This material can then be collected with other data as ISMS grids for development of alternatives which can alleviate the situation.

NATIONAL AMBULATORY MEDICAL CARE SURVEY—Three thousand physicians throughout the nation will be receiving letters asking for their cooperation in a survey conducted by the National Center for Health Statistics, to gather data on the public's use of ambulatory medical services in physician's offices. Participation in the survey will involve completion of very brief patient forms for approximately ten patients each day. Completion may be done by the physician, or a member of his staff, the form requires about a minute to fill out.

A few physicians in Illinois may be contacted, if you are among them please give this effort your full cooperation. Only by active participation can accurate statistics be compiled. The survey is being promoted by the American Medical Association.

NEW PROCEDURE FOR COMBINATION MEDICARE-MEDICAID CLAIMS—To facilitate rapid payment, MDs should no longer mail a copy of the Medicare Claim Form (1490) to the Ill. Dept. of Public Aid (IDPA) when submitting combination Medicare-Medicaid claims. Physicians should keep a copy of the 1490 and send the original to the Medicare carrier. After receiving from the carrier an Explanation of Medicare Benefits (EOMB) form, the MD should attach his copy of the 1490 & mail both to IDPA for payment of that not covered under Medicare. The new procedure took effect Jan. 2 and officials thus hope to expedite claims.

PHYSICIANS IN THE NEWS—New president-elect of the American Society of Anesthesiologists is **John W. Ditzler, M.D.**, Chicago. Also a president-elect, **Paul Q. Peterson, M.D.**, Dean, School of Public Health, University of Illinois at the Medical Center, Chicago, of the American Association of Public Health Physicians.

New president of the Illinois Chapter of the American College of Chest Physicians is **Ruy V. Lourenco, M.D.**, of the Abraham Lincoln School of Medicine, Chicago. **Frank W. Newell, M.D.**, Chicago, has been elected president of the American Academy of Ophthalmology and Otolaryngology. Elected to a three-year term on the Board of Directors of the American College of Emergency Physicians was **Bill B. Smiley, M.D.**, Decatur.

President of the Chicago Committee on Trauma of the American College of Surgeons is **Howard W. Schneider, M.D.**, Harvey. At recent swearing-in ceremonies before Supreme Court Justice Kluczynski, **Herman Wing, M.D., LL.B.**, Chicago, was admitted to the Illinois Bar.

Warren Tuttle, M.D., Harisburg, was selected chairman of the Medical Examining Committee of the Department of Registration and Education, succeeding Kenneth Schnepp, M.D., Springfield. Dr. Tuttle also serves as ISMS Trustee from the Ninth District. Dale Richardson, D.O., Pontiac, was selected as Secretary of the committee. **David Rendelman, M.D.**, Carbondale, has been elected vice-chairman of the Health Care Facilities Planning Board of the State of Illinois. **Richard S. Wilbur, M.D.**, Chicago, recently was named senior vice-president for medical affairs of Baxter Laboratories, Morton Grove.



President's Page

THE LIABILITY DILEMMA

For many years, professional liability has been recognized as an area of major concern, but the primary thrust of measures to contain the problem has been directed at assuring availability of insurance protection.

Provision of such protection—necessarily in ever-greater amounts—has served only to present more lucrative targets to the trial lawyers, and to encourage more patients to seek undue or unduly-large awards for the real or imagined untoward results of treatment. The "lottery mentality" can be discerned as an important influence in the awards sought, and the judgments rendered reflect the misconception that the insurance treasury is infinite.

The synergistic effect of these attitudes has rapidly propelled this problem from one of concern to one of crisis. Insurance carriers are either abandoning the field or refusing coverage to all but the low risk groups. Such actions have created havoc and resulted in a serious curtailment of the practice of medicine. While Illinois has not yet suffered as severely as many states, we surely will if legislation is not forthcoming to inject the element of reason.

Your officers recently met with Governor Walker and apprised him of the problem and possible solutions. He shares our concern and has offered the assistance of the executive branch.

It is anticipated that the ISMS Board of Trustees—meeting later this month—will approve a recommendation of the Medical-Legal Council to enlist the help of the Illinois State Bar Association, Illinois Hospital Association and community leaders in constructing rational and reasonable remedies.

Legislation must be sought to limit the size of awards, modify the contingency fee, establish a workman's compensation-type mechanism for medical injury, restore the locality rule, re-establish a reasonable statute of limitations, and eliminate from the complaint a statement of monetary award claimed.

The success of these proposed legislative efforts will rely upon the full and earnest support of each member. In the interim, let your patients and community leaders know what a serious problem this is; that it is their problem—not ours alone; that they indeed are paying for it, and that the present professional liability climate has an unfavorable affect upon medical care.

Fredric D. Lake

Fredric D. Lake, M.D.


Today's woman doesn't want to
spend a lot of time searching for a
contraceptive she's comfortable with.

Ecological Elements of Vibration (Chippers') Syndrome

By Domingo Leonida, M.D., M.P.H./Lincoln

"All physiological, behavioral and pathological responses of the human body are the result of deformations of body tissue. . . ."[1] There is nothing in a foundry so anxiety-provoking in a sustained manner as the chippers' syndrome. Finger-blanching, numbness, hand swelling and loss of grip inspire among old and young chippers the fear of being deformed, its permanence or incurability. Even the chippers' perception is affecting by the distortion.

The role of vasospasm and neurological events attending this syndrome are well known.[2] Nerve ends in the wall of digital arteries and arterioles changed and increased reaction to cold in Raynaud's phenomenon due to vibrations.[3,4] The vibration tend to involve the entire body with various part vibrating at different rates and thus can give rise to pain.[5] Undoubtedly, further work in elucidating the pathophysiology of Raynaud's phenomenon of occupational origin is desirable.[6] Research to elaborate upon adaptive man-environment relations in industry from an ecologic perspective has more than an intrinsic value.[7] Raynaud's phenomenon of occupational origin was mentioned as an uncommon occupational disease approaching extinction by the year 1960.[8] In foundries and similar plants it has rolled relentlessly to wreck havoc and anxiety among chippers and grinders.

Finger-Hand-Arm-Shoulder System Vibrations

This article is concerned with symptoms and signs referable to the fingers, hand, arm and shoulder involvement. The findings refer to handheld tools (air hammers) with speeds ranging from 1500 blows/minute to 2823 blows/minute and grinders with speeds from 6000 blows/minute to 22,000 blows/minute. The time exposure per day varies from 6.5 to 7.0 hours in what was called the world's largest automated gray iron foundry, Mapleton, Ill.

DOMINGO DOMINIC JOSEPH LEONIDA, M.D., M.P.H., is a lecturer in Rehabilitation and Physical Defects, Special Education Department, Illinois State University, Normal, and a Public Health Officer, Department of Mental Health, Lincoln State School, Lincoln. Dr. Leonida holds an MPH from the University of Michigan and received his M.D. from the University of Cincinnati College of Medicine. He is Board Certified in Preventive Medicine.

Results:

The acquisition of finger, hand, arm, and shoulder signs and symptoms by chippers and grinders was studied 1971-1972. Controls are individuals who were examined during the same period of time as the chippers and grinders.

Contrasts were made between those employees found during the pre-employment physical examination to have a short latent period vs. long latent period before symptoms (tingling, numbness, pain, loss of grip) were induced by the application of a sphygmomanometer around the wrists. To determine latent period, the pressure around each wrist was maintained at 10 mm. above the average diastolic pressure as long as needed to produce symptoms and signs: three to five minutes.

Table 1 gives a range in numbers of years experience using the air hammer among patients being treated at Mapleton, Ill.

TABLE 1

A Comparison of Foundry Employees Examined During a 16-Month Period, Mapleton, Ill.

	Using Air Hammer (or used air hammer within recent 24 months)		Not using Air Hammer	
	Sympto-matic	Asympto-matic	Sympto-matic	Asympto-matic
19 & under				181
20-24 yrs.	36	7	3	571
25-29 yrs.	28	4	4	464
30-34 yrs.	18	3	4	249
35-39 yrs.	16	3	2	241
40-over	9	2	3	182
Total	107	19	16	1888
Percent	85%	15%	0.01%	99.99%

No attempt was made to include those employees who became symptomatic due to causes of non-occupational origin. The graph in Figure 1 gives a display of the number of new employees (chippers and grinders) who became symptomatic.

Using the Archimeds' principle to determine volume, increases of 13% to 20% in volume were most effective in eliciting among the 42 symptomatic employees a sensation of swelling.

Discussion

The graph indicates employees (chippers and grinders) who were symptomatic. The data in the graph and in the tables were based upon those employees who came into the medical division for treatment, evaluation, consultation, or for appraisal.

Figure 1 shows the progression in numbers of symptomatic employees among recently hired chippers and grinders during a 8-month period. The curve for the progression of symptomatic chippers was distinct from that of the symptomatic grinders. Chippers were exposed to vibrations ranging from 1500 blows/minute to 2823 blows/minute. Grinders experienced vibrations from 600 blows/minute to 22,000 blows/minute.

Figure 1 demonstrates a longer latent period before development of symptoms and signs among grinders. Also the grinders appear more resistent to vibration (by their smaller number becoming symptomatic) than the chippers.

FIGURE 1: PROGRESSION OF THE NUMBER OF SYMPTOMATIC EMPLOYEES RECENTLY HIRED TO BE CHIPPERS AND GRINDERS (FEBRUARY, 1971 – JUNE, 1972).

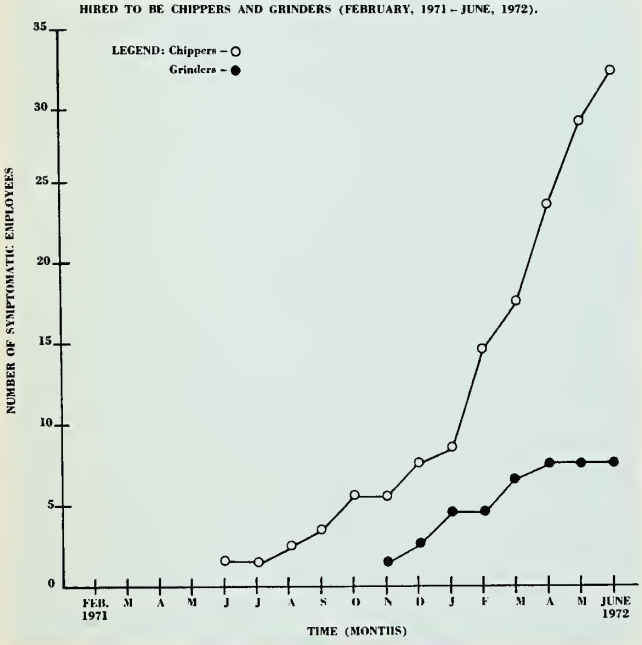


TABLE 2

A Comparison of Exposures to Vibrating Tools Among Symptomatic Chippers, Grinders and Others by Age Groups

	Age in Years				
Exposures	**20-24**	**25-29**	**30-34**	**35-39**	**40 & over**
under 1 yr.	1	1	2		
1-3 yrs.	21	14	11	8	5
4-6 yrs.		6	6	6	2
7-10 yrs.			3	6	5
11-14 yrs.				3	4
15-18 yrs.				2	3
19-22 yrs.					2
over 22 yrs.					1

Information about 144 chippers and 34 grinders who were hired before January, 1971, was included.

An attempt was made of displaying the number of new employees entering the "pool" of susceptible individuals (monthly). The number not symptomatic included those who might have transferred to other jobs, but who had entered the population of susceptibles when they were hired into the company as grinders or chippers and were not found to be symptomatic. From the population of susceptibles exposed to vibrating tools, some of these employees remain asymptomatic while a certain number of employees became symptomatic. The numbers in all columns become cumulative as progressing chronologically from one month to the next, except in the first two columns.

Analysis of Data

The number of employees (chippers) who were "lost" to the population exposed to risk of developing vibration syndrome each month were also studied. These were tabulated per month. These employees were lost through transfers to another plant in the same geographical area, changed jobs, promoted, and others became injured in such a manner as listed in Table 5, thus temporarily lost to the follow-up.

This miscellaneous group of 42 employees who were "lost" from the list of employees originally hired as chippers or grinders have applied for transfer within the same geographic area, changed jobs, or were promoted to another job.

The data do not include all employees using air hammers and all employees not using air

hammers in the plant. Data on employees examined for various reasons as well as complaints of numbness, white fingers, loss of grip, swelling or tingling of hands, pain in the hands, elbows and shoulders, were gathered during a 16-month period. Many of those who were not currently using vibrating tools but were symptomatic had a history of previous exposures to vibrating tools. Others had neuritis of nonoccupational origin.

Employees were followed from the time of the pre-employment physical exam during an 8-month period of prospective follow-up. Those who had a long latent period seemed resistent to developing symptoms and signs commonly associated with vibration syndrome.

Those with a short latent period, which could be determined during the pre-employment physical examination, seemed to have the highest risk of developing vibration (chipper's) syndrome.

Although some people claimed that the turnover among employees exposed to vibratory tools is 100%, such a turn-over of 100% may be realized only after 23 years, 22 years, 18 years and so on as tabulated in Table 2.

Symptomatic foundry employees includes current chippers and grinders as well as symptomatic ex-chippers and ex-grinders. The latter group had been off vibratory tools within a 24-month period. Most of the symptomatic employees had been using vibratory tools between 1 and 14 years and in age, range from 20 to 51 years of age. A negligible number of symptomatic employees had used vibratory tools in this foundry for a period less than one year but their previous experience in the use of such tools elsewhere extend over two to three more years.

Occupational hazards to which chippers or grinders are exposed are numerous. Acute backs, fractured metalarsals, fractured metacarpals, head injuries, contusion of the testicle and cervical sprain headed the list during a 16-month period. The 31 with chipper's syndrome were confirmed as such by either a consulting neurologist or a neurosurgeon, both of whom are board-certified in their specialty. The group claiming white fingers, numbness, swelling of the hands and loss of grip numbered 74.

Because of more time and increasingly more opportunities for leisure activities among many people, numbness and swelling of the hands, white fingers and loss of grip must be more seriously considered than in the past as they pertain to a constellation of factors (at work and off work) affecting the quality of life, including an individual's hobbies or recreation.[9] Special examinations and care of trauma among industry's employee have a special mission.[10] Although considerable variability in vibration frequency exist in using these tools, complications to the problem abound. Among the latter are "whether the tool is held in the hand and applied to the job or the job held in the hand and applied to the tool, personal susceptibility and skill, and the hardness of the metal being worked."[11]

In current literature studies and discussions about the transport filament hypothesis (accounting for transportation of small particulate substances, proteins, polypeptides and free leucine which move down the nerve fibers at the same rate) may help explain the patho-physiology of vibration syndrome of occupational origin. The presence of a system of fast transport of materials in the nerve fibers and the "trophic" substances conveyed from nerve to the postsynoptic cell to control the spatial extent of receptors in the muscle membrane, as well as the speed of contraction and, the general metabolism of the muscle fiber are worthy of further study, this time from a pathologic physiology view point.[11]

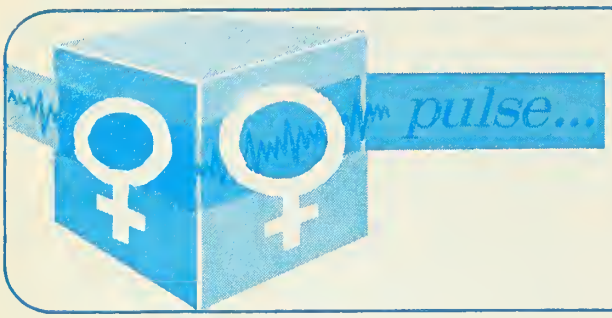
Summary

A group of hourly employees were followed-up to determine the rate with which such a group became symptomatic while using air hammers and grinders in a modern foundry. An occupational "Life" Table was designed to display by a graph the progression of symptomatic employees from the increasing population at risk of developing vibration syndrome. The numerous hazards in the plant to which chippers and grinders are subjected were tabulated. The risk of developing white fingers, numbness, tingling, swollen hands, loss of grip, painful shoulders and elbows were greatest among users of air hammers in contrast to other employees using grinders or no vibrating tool. Where employees labor in such environment largely determined what metabolic, ecologic and psychologic effects actually accrue. A possible screening procedure using a sphygmomanometer to determine risk of vibration syndrome was explored. Inverse variations were observed. The shorter the latent period the higher the risk developing vibration syndrome within a short follow-up period of time. ◄

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of the doctor's wife

Mrs. Harold Keegan, Editor

North Central Regional Workshop

The following are two of the reports from the North Central Regional Workshop held October 17-18, 1974, at Oakbrook, Illinois



Attending the Workshop were: First row (from left) Mrs. Alton Morris, Legislation; Mrs. Edward Szewczyk, Vice-president Community Health; Mrs. Wendell Roller, Communications. Second row (from left) Mrs. R. S. Hoover, Health Manpower; Mrs. Donald Rager, AMA-ERF; Mrs. Ralph Davis, Vice-President Membership; Mrs. Paul Wochos, Family Health; Mrs. Eugene Vickey, President-elect.

Communications Talk Shop

prepared by Mrs. Wendell Roller, Communications chairman.

What we do, and how we tell it, equals reputation—that is, our performance and communication. Our performance is judged by the degree the Auxiliary meets community needs. Our communication expresses the degree of concern we have for people and this requires 'Listening' as well as 'Telling.'

To be a good Communicator, Mrs. J. Paul Sauvageot, Editor-in-Chief, MD's Wife, recommended the following points to consider:

1. Apply your intelligence by giving thought to the content.
2. Be a generalist; see the overall picture.
3. Generate alternatives so there is freedom of choice and opportunities to be flexible.
4. Be sensitive to problems.
5. Cultivate a mature childlikeness: be receptive to new ideas, be enthusiastic and be sincere.
6. Write about something new that will be acceptable.
7. Plan your communication program: develop a broad plan for the year, evaluate your ideas and decide on your course of action.

Mrs. M. Sloan, II, Chairman, suggested seven 'Tips to the State Communication Chairman:'

1. Have a State Communication Committee.
2. Make a year's calendar of activities.
3. Plan a state orientation session on Communication for the Board.
4. Have a state workshop on Communication.
5. Have a Talent Bank in which you file the talents of your members.
6. Be catalysts: Reach out into the community and bring together organizations who will work together in health projects.
7. Develop resources for County Auxiliaries and members as program tools, speakers bureau, etc.

Communication includes press, publications, radio, TV and telephone. These outlets can be used by members to talk to the state auxiliary as well as the state auxiliary to talk to the members. They are our tools to inform, focus on an emphasis, give continuity to efforts, exchange ideas and encourage each other. With communication it is possible to further understanding and work toward a Better Quality of Life!

prepared by Mrs. Edward Szewczyk, Vice-president Community Health.

Community Health

It was a bright, crisp October day at Oakbrook, Illinois, when the giant machines began to roll. There were rooms full of input cards and the output, of course, was overwhelming. My mind darted quickly about, trying to plan the best strategy to gather the most worthwhile information for my own consumption—in high hopes that I could transmit some of the excitement to the auxiliary members of Illinois.

After pausing briefly at the "Talk Shop," where I observed the masterful input of AMA leaders Liljestrand, Wilkinson, and Company, I finally settled in at the "Talk Ins." There our Captain Gilliland mustered together all the input of the community health forces and the output began to pour forth—fantastic program realities and possibilities covering numerous health needs of the nation: Immunization—not just for one month or one year, but year-round —perhaps reminders printed on milk cartons, but certainly reaching expectant mothers; Safety —Defensive Driving Campaigns, Infant Carrier Seats, Home and Kitchen Safety, the "Heimlich Maneuver" which prevents death by choking (called the Cafe Coronary), Medical Alert Tags, School Poster Contests, and the declaration that the last week of October would annually be "National Safety on the Streets" week; Talking Books for those with vision or other physical impairment that prevents reading; Homemaker Services; Meals on Wheels; Children with learing disabilities; Volunteers to Troubled Youth; "Worry Clinics;" Child Abuse Prevention Programs; Parent Effectiveness; Action for Childrens' Television; Stroke Rehabilitation; Teacher Competency in Health Education.

These and many other programs are actually being carried out by the Medical Auxiliaries or under their direction.

One bright red card kept popping out during the sessions—*"PRIORITIES"*—establish them. Survey your community to identify health needs. Explore resources already available and discover if they are being utilized. Communicate—even if it means just listening.

I stubbornly kept trying to insert a card—*"PHYSICAL FITNESS FOR AUXILIARY MEMBERS."* It was rejected time after time with the words **"Unacceptable to Smokers and Drinkers."** With so much positive action, I went away with hope for the bit of negative—for I shall try again.

Vitamin K Deficiency

(Continued from page 61)

Summary

Certain infants are at particular risk of developing a hemorrhagic diathesis due to vitamin K deficiency. These include infants born to mothers receiving anticonvulsants, breast fed infants, and infants with acute and chronic diarrhea. Also at risk are those children with chronic malabsorption syndromes secondary to biliary atresia, cholestasis or cystic fibrosis. In chronic malabsorbers an oral, water soluble vitamin K should be administered once a week.

Appropriate therapy for vitamin K deficiency is 1 mg of vitamin K_1 (Mephyton and Aqua-Mephyton). If the 1 mg dose does not lead to cessation of the bleeding within an hour it is safe to conclude that the problem is not vitamin K deficiency. There are no complications and no dangers to giving 1 mg of vitamin K. ◄

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View Box

(Continued from page 62)

DIAGNOSIS: *Linitis Plastica of the Colon*—Linitis plastica is a diffuse intramurally infiltrating anaplastic carcinoma characterized by microscopic tumor cells (signet ring cells) with diffuse inflammatory and fibrotic change. Characteristically they look like an inflammatory lesion rather than a carcinoma and usually occur in the rectum or sigmoid colon, but may be seen in other segments of the colon. There is a higher incidence in association with previous ulcerative colitis. The segment involved is usually quite long with tapered margins rather than the shelfing deformity seen in carcinoma. There is rigidity on the fluoroscopic examination. The mucosal folds may be intact, which accounts for the lack of bleeding as a symptom. At surgery the lymph nodes are almost always involved and a very poor prognosis is associated with this disease.

Chipper's Syndrome

(Continued from page 79)

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Drugs in Gastrointestinal Diseases

By Ruven Levitan, M.D., F.A.C.P./Chicago

Gastrointestinal ailments can be managed by surgical, dietary, and pharmacological methods. We will limit our discussion here to the proper utilization of drugs in these conditions.

A current survey of the drugs used in gastrointestinal diseases would find that the following categories are widely prescribed: 1) antacids, 2) anticholinergics, 3) pancreatic enzymes, 4) corticosteroids, 5) immunosuppressive agents, 6) antibiotics, 7) hematinics, 8) antiparasitic drugs, 9) laxatives and stool softners, 10) antidiarrheal agents, 11) Pitressin, 12) agents used to manage hepatic encephalopathy e.g. lactulose, 13) diuretics, 14) cholestyramine, 15) gamma globulin, 16) local anesthetics, 17) vitamins, 18) tranquilizers. This list is not complete and one also would have to include different food supplements such as medium chain tryglycerides and predigested food substances e.g. Vivanex.

In the management of any gastrointestinal diseases the following must be kept in mind: 1) that we are lacking critical and objective evaluation that permits us to assess the usefulness of many agents used in the treatment of different gastrointestinal diseases; and 2) that the more chronic and fluctuating the natural history of a disease is, the more difficult it is to determine the value of any drug in its management and the more crucial it is to have carefully double-blind prospective controlled studies to evaluate drug efficacy. Unfortunately, the state of the art is such that these criteria can not be fulfilled at this time, and in talking about any drug management in gastrointestinal diseases one has to take the information with a grain of salt due to lack of definitive scientific data.

RUVEN LEVITAN, M.D., F.A.C.P., is Chief of the Gastroenterology Sections ot the VA West Side Hospital and the Abrohom Lincoln Schaol of Medicine, Chicogo. Dr. Leviton, certified in internol medicine ond gostroenterology, hos outhored over 100 scientific articles ond obstrocts.



Antacids

Antacids have been utilized extensively in the management of upper gastrointestinal diseases especially duodenal ulcer, gastric ulcer, gastritis, hiatus hernia, and esophagitis. Many of these agents are sold over the counter. As judged by quantities consumed, this group of drugs accounts for a multimillion market per year. The use of antacids is logical on theoretical grounds based on the accepted dictum "no acid, no ulcer." While clinical experience supports the fact that antacids relieve pain in most patients with peptic ulcer, there is no convincing evidence present which would prove conclusively that antacids significantly accelerate the healing rate of ulcers or that their ingestion will prevent recurrences of ulcer formation.

The primary goal of antacid therapy is certainly the relief and prevention of pain in ulcer patients and the continuing neutralization of gastric acid and thus peptic activity.

The limiting factors in successful neutralization of gastric secretions are the rate of gastric secretion on one hand and of gastric emptying on the other. No matter how effective the antacid is, it must remain in the stomach for a long enough time in order to neutralize the acid secreted. The stomach empties itself at different rates in different individuals and after different meals, therefore, it is not surprising that the amount of antacids needed to achieve neutralization of gastric contents also varies widely from patient to patient. It is crucial then that the administration of antacids be frequent enough. Studies in patients have shown that neutralization of gastric juices was achieved for periods of 20-35 minutes after aluminum hydroxide ingestion. Sodium bicarbonate, the chemical most effective antacid available, was able to neutralize gastric acids for not longer periods than 45 minutes. Therefore, if the aim of antacid therapy is to lower the gastric pH, one should give antacids frequently and not less often than every hour between meals. It should be pointed

out that liquid antacids are much more effective than tablets in achieving neutralization of gastric juice and this should be the preferred mode of administration of these agents. It is unfortunate that most patients are unwilling to continue with regularity adequate antacid therapy for any prolonged period of time, especially after the subjective symptoms subside.

In prescribing antacids one has to keep in mind that many of these preparations have significant amounts of sodium chloride in them and that in patients who have congestive heart failure, cirrhosis, or renal disease this may be a rather important factor. The physician must calculate the amount of salt he is giving his patient on a precsribed schedule and take into account whether sodium restriction is an overall goal in the management of this particular patient's problem. Administration of antacids one hour after meals has been shown to delay gastric emptying and the antacid given at that time will be more effective for a more prolonged period of time.

Anticholinergic Drugs

This is another group of drugs which have been used extensively in the management of gastrointestinal diseases. Bellodonna and atropine are probably the best and all the other commercial preparations probably do not have large pharmacological advantages over these two basic ones. Bellodonna has a distinct advantage in that one can titrate the dose for each individual patient by varying the dose according to need. It should be stated that in order for anticholinergics to be effective in reducing gastric secretion and motility and in decreasing motility of the gut, one has to give them to the point where side effects occur. Anticholinergics will rarely be effective without producing some side effects, a point that has to be clearly explained to the patient. Naturally, anticholinergics should not be given if a contraindication to their use is present. The aim of the administration of anticholinergics is to reduce gastric acid secretion especially in the basal state, reduce gastric emptying time and thus augment the action of given antacids, to reduce pancreatic secretions in certain conditions, reduce the motility of the intestine when such a state seems to be present.

So far, there is no objective evidence available to prove that administration of anticholinergics will alter the natural history of peptic ulcer. In some patients, however, it is my clinical experience that ulcer pain will not disappear on antacid therapy alone, but will be ameliorated and eliminated when anticholinergics are added to a regular antacid schedule. There is only one study available in the literature which seemed to suggest that glycopyrolate (Robinul®) lowered the incidence of duodenal ulcer recurrence rate when given for a long period of time as a preventive measure. Unfortunately, no other studies are available to confirm this clinical observation at this time.

Salicylates

Salicylates are being used rather extensively by the public both with prescriptions and in over the counter drugs. Since salicylates have been incriminated as causing a higher incidence of G.I. bleeding in patients with peptic ulcer disease and a possibility of also causing gastritis, it is important to know a few facts about their pharmacology. Salicylic acid has a pKa of 3.5. At a pH of 3.5, 50% of salicylic acid is ionized. At the pH of 5.5 about 99% is ionized. In the undissociated lipid soluble form acetylsalicylic acid is rapidly absorbed by the gastric mucosal. Mucosal damage and bleeding have been found to be associated with such absorption. Mucosal damage can be prevented or decreased by neutralizing the gastric contents effectively. The small amounts of antacids present in most "buffered aspirin" preparations are ineffective in altering significantly the gastric pH, a fact that should be stressed.

Immune Serum Human Globulin

Immune serum human globulin has been utilized for the prevention of viral hepatitis (MS-1 type). It is also a useful agent for patients who have a gamma globulin deficiency with and without associated malabsorption. Human serum globulin has 16.5% protein in it. It will prevent viral hepatitis (MS-1 type) when given 1-2 weeks after exposure and, therefore, the clinical illness can be prevented in 80-90% of subjects exposed. The recommended dose is .01 ml/per lb. of body weight or 0.02 ml/Kg of body weight. In some patients the administration of gamma globulin will produce a subclinical disease, namely, one will be able to find an elevation of serum transaminase and a change in other liver function tests and be able to demonstrate abnormalities on liver biopsy. However, most of the subjects will do very well if the gamma globulin is administered in time.

The question is who should receive gamma globulin and what is the definition of exposure? It is recommended that household contacts of a patient who has a proven case of viral hepatitis should receive gamma globulin. On the other

hand, school contacts do not have to receive it unless contact was extremely close. In institutions such as prisons or dormitories for children where the contact between subjects is quite close and cleaniness is not always perfect, the administration of gamma globulin is recommended to roommates and associates. Medical and other personnel who work in hemodialysis units or hospital contacts should not receive gamma globulin if the patient had, indeed, proven serum hepatitis (MS-2). The same applies for office or factory workers who do not need such injections. If, however, the person was exposed to common source of exposure such as water supply, then administration of gamma globulin would be recommended. Persons who work with nonhuman primates who had viral hepatitis are very susceptible to the infection and so are travelers to foreign countries where the disease is epidemic. These groups of individuals should receive immune serum globulin.

Management of Hepatic Encephalopathy

The management of hepatic encephalopathy both in the acute and the chronic stage constitutes removing the cause of liver damage, if possible, restriction of protein intake, correction of fluid and electrolyte imbalance, stopping G.I. bleeding, treating any existing infection, cleansing of the gut, and administration of antibiotics especially of Neomycin which are supposed to be able to eliminate the urea-splitting, ammonia producting microorganisms from the colon. Neomycin is the drug of choice at this time but it has many drawbacks: 1) it produces malabsorption when used for a prolonged period of time; 2) it may produce renal damage if the drug is absorbed; and 3) it may be associated with higher incidences of enterocolitis. In a comatose patient the administration of Neomycin pills is difficult in that one must crush the tablets and give it by nasogastric tube. No wonder, therefore, that great interest was created when a new agent was proposed in Europe for the treatment of hepatic encephalopathy. The utilization of this agent was actually suggested by Dr. Ingelfinger when he was editor of the YEARBOOK OF MEDICINE in 1963. The first experiments with this new agent, Lactulose, were done in Europe. Lactulose is a synthetic dissacharide which is used as a laxative quite extensively now on the continent. Lactulose is essentially not absorbed in the small bowel and arrives to the colon where it is being split by bacteria into lactic acid and other acids. Consequently, the colonic pH becomes more acid and the NH_3 in the colon is converted to NH_4. The NH_4 cannot diffuse into the blood stream and, therefore, the absorption of ammonia from the colon is stopped. Actually, a gradient is created for the ammonia to diffuse the other way around from the blood into the colon if the blood ammonia level is high. This agent has been reported as being quite effective in the management of hepatic encephalopathy in the studies done in Europe. Side effects of this drug are essentially limited to diarrhea. The recommended dose has not been firmly established, but it is between 25-45 ml of 25-37.5% solution of the drug given t.i.d. The drug has not yet been approved for use in the United States by the Food and Drug Administration, but hopefully, with the outcome of additional human experiments it will soon become available. This drug should have several advantages, namely, it can be injected through a tube in the comatose patient into the stomach and colon; 2) its action will not be prevented by microorganisms which are resistant to Neomycin or other antibiotics; and 3) hopefully, no side effects such as those which occur after the use of Neomycin. One would have to await additional information as it accummulates on the utilization of this new agent.

Medium Chain Triglycerides

Medium chain triglycerides may be a very useful coloric substitute in the management of patients with several conditions associated with malabsorption, especially intestinal lymphatic obstruction, lymphomas, pancreatic exocrine insufficiency, bile salt deficiency, mucosal disease of the small bowel and the short bowel syndrome, and also in patients after gastrectomy. Medium chain triglycerides have 6-12 carbon chain links. Their absorption is less dependent on the presence of bile salts and lipase in the gut than that of long chain fats. These agents are transported directly through the portal system as fatty acids and do not have to pass through the lymphatics and, therefore, whenever you have a lymphatic block in the intestine which prevents absorption of fat these agents are extremely useful as a coloric source. The medium chain triglycerides are converted in the liver to carbon dioxide and ketone bodies. They seem to be an extremely good source of calories in patients with various states of malabsorption. My personal experience has been extremely gratifying in malabsorption after gastrectomy, in patients who had the short bowel syndrome and also in patients with intestinal lymphomas.

Predigested Foods

Predigested foods such as Vivanex are a useful by-product of the space program. These agents contain essential and nonessential amino acids, carbohydrates, vitamins, minerals, fatty acids. Vivanex is extremely well absorbed in the upper small bowel and, therefore, is a good source of calories in patients who have severe malnutrition, short bowel syndrome, severe pancreatic insufficiency, and who are unable to digest any large volumes of food. A preparation similar to Vivanex is W-T Low Residue Food which has recently been placed on the market by Warren-Teed Pharmaceuticals. Presumably, this agent will be useful in patients who need food supplement but who are lactose deficient. In my opinion, and the opinion of most patients, all the preparations available so far are not pleasant to the taste and must be served chilled with a little salt added in order to obtain some patient acceptance. So that the patients can tolerate it better, I have found it useful to prescribe these substances with a mixture of 7-Up or other carbonated beverage prepared in a blender. Notwithstanding the problem of patient acceptance, this approach to therapy has made great strides and has helped us a great deal in caring for patients with small bowel resections, malabsorption syndromes, mucosal diseases of the small bowel, pancreatic insufficiency and patients after surgery who are malnourished.

Summary

I have only touched on several of the many agents used in the management of gastrointestinal diseases. I would like to emphasize that the most widely used drugs are antacids and anticholinergics. Unfortunately, these are often used improperly. I would suggest that if antacids are prescribed they should be given frequently enough to achieve neutralization of gastric acid, try to avoid side effects such as diarrhea, avoid giving too much magnesium and overload with salt and calcium. Anticholinergics should be used with caution in patients who have contraindications and one must prescribe the dose to the point where side effects are present in order to achieve therapeutic results. ◄

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South: 2711 W. 183rd St., Suite 215, Homewood • Call: 799-0160
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COOK COUNTY

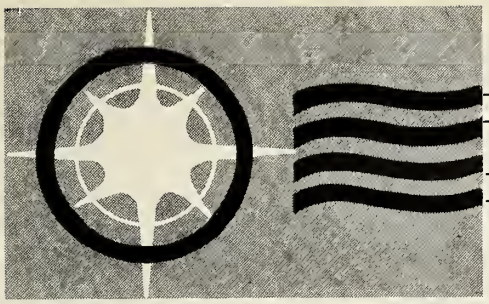
Graduate School of Medicine

CONTINUING EDUCATION COURSES
STARTING DATES — 1975

SPECIALTY REVIEW IN NEUROLOGICAL SURGERY, Feb. 1
SPECIALTY REVIEW IN SURGERY, PART II, March 10
SPECIALTY REVIEW IN PEDIATRIC SURGERY, Feb. 17
SPECIALTY REVIEW IN PEDIATRICS, April 7
PRE & POSTOPERATIVE CARE OF PATIENTS, 4 Days, March 4
SURGERY OF G. I. TRACT, One Week, April 7
BLOOD VESSEL SURGERY, One Week, April 14
BASIC ELECTROCARDIOGRAPHY, One Week, March 3
BASIC INTERNAL MEDICINE, One Week, March 17
REVIEW IN NEUROPATHOLOGY, One Week, March 10
NEUROLOGY, Part I, Basic, March 17
ADVANCES IN UROLOGY, Two Days, March 3
NEWER UROLOGIC INSTRUMENTATION, One Day, March 5
PEDIATRIC UROLOGY, Two Days, March 6
FAMILY PRACTICE REVIEW, One Week, April 7
DIAGNOSTIC RADIOLOGY, One Week, April 14
ADVANCES IN NEONATOLOGY, Two Days, April 21
STATE & NATIONAL BOARD REVIEW, Basic & Clinical, April 27 and May 5

Information concerning numerous other continuation courses available upon request.

Address:
REGISTRAR, 707 South Wood Street, Chicago, Illinois 60612



membership forum

October, 1974

Dear Editor:

Your insightful editorial on "Anger" in the August, 1974, *Illinois Medical Journal* is a gem of common-sense introspective psychodynamics. It is tragic, however, than an appreciable, increasing number of our citizenry are so impulse ridden that their rage is discharged via the neuromuscular flexion of the indicis proprius onto the lethal trigger of a hand-gun. The 22 persons slain and another 76 shot and wounded over the Columbus Day week-end bares mute evidence to our need for Federal handgun control legislation.

In keeping with the theme of your essay, I am enclosing a poem—"Ode to Non-Violence"—that I penned in 1960. I hope that you may consider it suitable to publish for your reader's attention.

Sincerely yours,
Kermit T. Mehlinger, M.D., FAPA
President, South Side Branch, Chicago Medical Society

"ODE TO NON-VIOLENCE"

If you would whip me
on my pate
Shall I wish you love
or wish you hate?
If I wish you love
and don't retaliate
Perchance, death will be my fate.

If I wish you hate
and defend myself
I may be able
to preserve my health
If I turn on my cool
and sublimate my hate
Ulcers and hypertension
will be my fate.

So of the three choices
I'll take number two
And be violent or non-violent
Just like you.
My cup runneth over
From turning the other cheek
My defenses are exhausted
And I'm very weak
I'll play the game fair
And square up to you
As long as you promise
To be non-violent too!

Kermit T. Mehlinger, M.D.

November 11, 1974

Dear Doctor Kravitz:

I recently saw a synopsis of your editorial which appeared in the *Illinois Medical Journal,* August, 1974.

We also are very concerned about the unrestricted use of trampolines in our elementary and secondary schools. I recently searched the literature for any information on this subject and did not find any recent articles. I was pleased that you had taken the time to write this article and would very much like to have a reprint and also any other current information you may have on the subject.

My partner and I are in the midst of a "discussion" with the athletic department of our local high school on this very subject and any information that you have would be most appreciated and helpful.

Sincerely yours,
David W. Jenkins, M.D.
Trenton, New Jersey

November 12, 1974

Dear Doctor Van Dellen:

This letter is in reply to Ms. Susan A. Brame of St. Elizabeth Hospital, Chicago, Illinois.

The Accident Prevention Committee of the American Academy of Pediatrics in our spring in 1974 endorsed Doctor Stolovis' recommendation to ban the trampoline as a sport in the public schools. The Washington Chapter of the American Academy of Pediatrics has also made the same recommendation. As a member of the Accident Prevention Committee I have written the editorial affirming this position.

Sincerely,
Harvey Kravitz, M.D.
Member, Accident Prevention Committee
American Academy of Pediatrics

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

MEDICINE FOR TODAY—Spring Sessions

For: **All practicing physicians, house staff. IAFP's 26th Annual Lecture Series, with A-V and Q&A suplement. Emphasis on Orthopedics, Psychiatry, Endocrinology, & Pulmonary Function. *CME Credit:* 30 hrs. (maximum, for Fall, 1974, & Spring 1975 sessions) AAFP Prescribe, AMA Category 1. *Fee:* $90 AAFP mbrs., $100 non-mbrs. Meets in these cities on dates noted:**

***Belleville*—Feb. 13, 20, 27, Mar. 6, 13, 20.**
***Berwyn*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Centralia*—Feb. 19, Mar. 5, 19.**
***Champaign*—Feb. 13, 27, Mar. 13.**
***Chicago Nearwest*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Chicago North*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Chicago Southwest*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Harvey*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Hinsdale*—Feb. 12, 26, Mar. 12.**
***Melrose Park*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Park Ridge*—Feb. 12, 19, 26, Mar. 5, 12, 19.**
***Peoria*—Feb. 13, 27, Mar. 13.**
***Rockford*—Feb. 13, 20, 27, Mar. 6, 13, 20.**
***Rock Island*—Feb. 13, 27, Mar. 13.**
***Springfield*—Feb. 20, Mar. 6.**

For details of time and place, contact: Ill. Academy Family Phys., 14 E. Jackson Blvd., Suite 1532, Chicago, IL 60604.

February, 1975

Cardiology

EKG DIAGNOSIS
For: Physicians—Gen. Interest. 3-day Workshop-Course, Feb. 18-20, U. of Mich., Ann Arbor. **CME Credit:** 21 hrs., AMA Category 1, AAFP Elective, AOA Elective. **Fee:** $120. **Sponsor:** Am. College of Emergency Physicians. **Contact:** Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104.

Emergency Medicine

EMERGENCY MEDICINE
For: Emergency Physicians. 4-day Workshop-Course, Feb. 25-28, 8:00 AM-5:00 PM, Ann Arbor. **CME Credit:** 28 hrs., AMA Category 1, AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor:** Am. College of Emergency Physicians. **Contact:** Robt. K. Richards, Director, Office of Intramural Education, Towsley Center, U. of Mich., Ann Arbor, MI 48104

Family Medicine

MEDICAL-LEGAL ASPECTS OF MEDICINE
For: Physicians. Lecture, Feb. 18, 7:30 PM, Elgin, IL. **CME Credit:** 2 hrs., AMA Category 1. **Sponsor, contact:** CME Committee of Sherman Hosp., 934 Center, Elgin, IL 60120.

Gastroenterology

PRACTICAL EXPERIENCES IN GASTROINTESTINAL ENDOSCOPY
For: Physicians and G.I. Assistants. Combined phys.-G.I. asst. 1st day, separate Seminars and Wkshps., 2nd day. Feb. 21-22, Playboy Club, Lake Geneva, WI. **CME Credit:** 14 hrs., AAFP. **Fees:** $200 (Phys.), $75 (G.I. asst.). **Deadline:** Feb. 18. **Sponsor, contact:** The Medical College of Wis., 561 N. 15th, Milwaukee, WI 53233.

General Medicine

GENERAL MEDICINE LECTURE SERIES—PART II
For: House Staff & General Staff. Weekly Lecture Series, Feb. 4, 11, 18, & 25, St. Mary of Nazareth. Chicago. **CME Credit:** 18 hrs. AAFP Elective. **Sponsor, contact:** Anthony Sapienza, M.D., St. Mary of Nazareth Hosp., 1120 N. Leavitt, Chicago 60622.

Internal Medicine

NEW DEVELOPMENT IN DIAGNOSIS AND MANAGEMENT OF LIVER DISEASES
For: All Physicians. Feb. 12, Chicago. **CME Credit:** 6 hrs., AMA Category 1, AAFP. **Fee:** $30. **Sponsor, contact:** U. of Chicago, Frontiers of Med., 950 E. 59th, Box 451, Chicago 60637.

Malabsorption Syndrome

MALABSORPTION SYNDROME
For: MDs & Nurses. Lecture, Feb. 26, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago. 60618. **Co-sponsor:** Eaton Lab.

Obstetrics & Gynecology

GYNECOLOGICAL LAPAROSCOPY
For: Gynecologists and Obstetricians. 3-day Course, Feb. 5-7, Chicago. **CME Credit:** 18 hrs., AMA Category 1. **Fee:** $250. **Reg. Limit:** 8. **Sponsor, contact:** Cook County Sch. of Med., 707 S. Wood, Chicago 60612.

Pathology

AGING AND MALIGNANCY OF THE ORAL MUCOSA
For: Dentists, Physicians, Pathologists. Symposium, Feb. 5-7, 8:30 AM-12:30 PM, Camino Real Hotel, Mexico City, Mexico. **Co-sponsor:** Mexico Dental Society. **Speaker:** P. D. Toto, D.D.S., Orban-Loyola Memorial. **Fee:** $50. **Reg. Limit:** 100, **Deadline:** Jan. 1. **Sponsor, contact:** P. D. Toto, D. S. or A. W. Gargiulo, D.D.S., Orban-Loyola Memorial, 2160 S. First, Maywood, IL 60153.

Pediatrics

SPECIALTY REVIEW COURSE IN PEDIATRIC SURGERY
For: Pediatricians. 5-day Course, Feb. 17-21, Chicago. **CME Credit:** 38 hrs., AMA Category 1. **Fee:** $200. **Reg. Limit:** 85. **Sponsor contract:** Cook County Grad. Sch. of Med., 707 S. Wood, Chicago 60612.

(No Title Available)
For: Pediatricians & Physicians. Monthly Meeting, Feb. 18, Dinner 7:00 PM, Program 8:00 PM, Sheraton-Blackstone Hotel, Chicago. **Fee:** $12.00 (dinner). **Co-sponsor:** Institute of Medicine of Chicago. **Sponsor, contact:** L. M. Zollar, M.D., Chicago Pediatric Society, 121 West 154th, Harvey, IL 60426.

Pharmacology

CLINICAL PHARMACOLOGY IN CONGESTIVE HEART FAILURE
For: MDs & Nurses. Lecture, Feb. 19, 11:00 am, Chgo. **Speaker:** A. Brest, MD, Prof./Med., Jefferson Med. Col'ege, Phila., Pa. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618. **Co-sponsor:** Am. Soc. for Clinical Pharmacology & Therapeutics.

Psychiatry

CURRENT AND FUTURE PERSPECTIVES IN BEHAVIOR MODIFICATION
For: Psychiatrists. Lecture. Feb. 19, Forest Hosp., Des Plaines, IL, **Speaker:** I. Goldiamond, Ph.D., U. of Chicago. **Fee:** $15 (Student rate: $5). **Sponsor:** Forest Hosp., 555 Wilson Ln., Des Plaines, IL 60016. **Contact:** June Bengtsen, PR Dept. (312) 827-8811, X362.

Surgery

GASTRIC & DUODENAL ULCERS—SURGICAL APPROACH
For: MDs. Grp. Discussion, Lecture, Grp. Discussion, Feb. 21, 10:00 am, S. R. Forkosh Hosp.; 6:00 pm, Lincolnwood Hyatt House; Feb. 22, 10:00 am, Bethany Methodist Hosp. **CME Credit:** 5 hrs., AAFP. **Fee:** $10 (other than staff for dinner). **Sponsor contact:** P. Thorek, MD, Chm., FAB^3/CME, 850 W. Irving Pk. Rd., Chgo. 60613.

MEDICAL AND SURGICAL ASPECTS OF ISCHEMIC HEART DISEASE
For: MDs. Symposium, Feb. 19, Itasca Country Club, Itasca, IL. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Reg. Deadline:** Feb. 17. **Sponsor, contact:** Ms. L. Widmer, Exec. Sec., DuPage County Med. Soc., 646 Roosevelt Rd., Glen Ellyn, IL 60137.

March, 1975

Alcoholism

ALCOHOLISM
For: MDs. Lecture, March 4, Chgo. **Speaker:** S. Nieder, MD, Dir./Alcoholic Treatment Unit, Martha Washington Hosp. **Sponsor:** Chgo. Med. Soc., N. Shore Branch. **Contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618.

Anesthesia

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS
For: MDs. 5-day Course, March 3-7, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor,** contact: Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING
For: MDs. 5-day Course, March 10-14, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $300. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Bronchoesophagology

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY
For: Residents or MDs of Otolaryngology. 6-day Course, Chgo. **Speaker:** P. Holinger, MD, Dir./Otolaryngology. **CME Credit:** 45 hrs., AMA Cat., 2. **Fee:** $300. **Reg. Limit:** 20. **Sponsor, contact:** Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

Geriatrics

RECENT ADVANCES IN GERIATRIC MEDICINE
For: All MDs. 1-day Course, March 8, Chgo. **CME Credit:** 8 hrs., AMA Cat. 1. **Fee:** $50. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Glomerulonephritis

RECENT ADVANCES IN GLOMERULONEPHRITIS
For: MDs & Nurses. 4th Annual Lecture, March 12, 11:00 am, Chgo. **Speaker:** D. Earle, MD, Prof./Med., Northwestern Medical Sch. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.

Internal Medicine

BASIC ELECTROCARDIOGRAPHY
For: MDs. 5-day Course, March 3-7, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
ONE WEEK COURSE IN BASIC INTERNAL MEDICINE
For: MDs. 5-day Course, March 17-21, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neurology

NEUROLOGY, PART I, BASIC
For: All MDs. 5½-day Course, March 17-22, Chgo. **CME Credit:** 44 hrs., AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
REVIEW COURSE IN NEUROPATHOLOGY
For: Neurologists. 5½-day Course, March 10-15, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neuromuscular Disease

NEUROMUSCULAR DISEASE: CURRENT IDEAS IN DIAGNOSIS AND MANAGEMENT
For: All MDs. Second Wednesday of Month, March 12, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** Ms. E. Ehrman, Adm. Asst., U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

Neurotology

NEUROTOLOGY
For: Residents or MDs of Otolaryngology. 4-day Course, March 24-27, 9:00-5:00, Chgo. **CME Credit:** 25 hrs., AMA Cat. 2. **Speaker:** N. Torok, MD, Prof. of Otolaryngology, Dir. of Course. **Sponsor, contact:** Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

Ophthalmology

ANNUAL OPHTHALMOLOGY ALUMNI DAY, U. OF CHGO. DEPT. OF OPHTHALMOLOGY
For: Ophthalmologists. Day-long Lecture, March 5, Chgo. **Sponsor, contact:** J. T. Ernest, MD, Assoc. Prof./Ophth., U. of Chgo. Dept. of Ophthalmology, 950 E. 59th St., Chgo. 60637.

Psychotherapy

SEXUAL AND MARITAL PROBLEMS—BRIEF PSYCHOTHERAPY
For: MDs, Psychologists, Mental Health Workers. Conference, March 21, 8:30 am—7:00 pm, Pick Congress Hotel; March 22, 9:00 am—12:00 noon, The Chgo. Med. Sch., Chgo. **CME Credit:** 8 hrs., AMA Cat. 1. **Fee:** $75. **Deadline:** March 14. **Sponsor, contact:** J. Cowen, Dept. of Psych. & Behavioral Sciences, U. of Health Sciences/The Chgo. Med. Sch., 2020 W. Ogden Ave., Chicago, IL 60612.

Surgery

PEDIATRIC SURGERY
For: Pediatricians. Monthly meeting, March 18, Highland Park Country Club, Highland Park, Ill. **Fee:** Dinner Reservations, $12; social hr., 6:00 pm, dinner 7:00 pm, program, 8:00 pm. **Sponsor:** Chgo. Pediatric Society. **Contact:** L. M. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

PRE AND POSTOPERATIVE CARE OF PATIENTS FOR SURGEONS & SURGICAL SPECIALISTS
For: Surgeons and Surgical Specialists. 4-day Course, March 4, Chgo. **CME Credit:** 31½ hrs., AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo., IL 60612.

Surgery Trauma

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA
For: All MDs, Residents & Interns. 2-hr. Eve. Clinical Prog., March 18, Christ Comm. Hosp., 4440 W. 95th St., Oak Lawn; Lutheran Gen. Hosp. 1775 Dempster, Pk. Ridge, IL. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the AM. Coll. of Surgeons, 11255 W. 74th St., LaGrange, IL 60525.

Urology

ADVANCES IN UROLOGY
For: Urologists. 2-day Course, March 3-4, Chgo. **CME Credit:** 16 hrs., AMA Cat. 1. **Fee:** $80. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chicago, IL 60612.

APRIL, 1975

Basic Sciences

STATE AND NATIONAL BOARD REVIEW COURSE, BASIC
For: All MDs. 6½ day-Course, Apr. 27-May 3, Chgo. **CME Credit:** 58 hrs., AMA Cat. 1. **Fee:** $225. **Limit:** 85. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Cancer

AGRESSIVE TREATMENT OF CANCER: REWARD AND RISKS
For: MDs. 2nd Wed. of Mo., Apr. 9, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

BREAST CARCINOMA
For: All MDs. Short Course, Apr. 23, Gary. **CME Credit:** 6 hrs., AMA Cat. 1, AAFP. **Fee:** $35. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U. Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

Clinical Practice

COMMON LEGAL PROBLEMS IN CLINICAL PRACTICE
For: MDs & Nurses. Lecture, Apr. 16, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Family Medicine

BASIC GYNECOLOGY
For: All MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

General Interest

"PRACTIONERS & PROFESSORS PARTNERS IN CME" —3rd ILLINOIS CONGRESS ON CME
For: All interested in CME. Conference/workshop, Apr. 18-19, Chateau Louise, Dundee, IL. **CME Credit:** 9 hrs., AMA Cat. 1. **Fee:** $35. **Limit:** 100. **Sponsor, contact:** IL Council on CME, 360 N. Michigan Ave., Chgo. 60601.

Internal Medicine

FAMILY PRACTICE REVIEW
For: All MDs. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
ADVANCES IN MEDICINE
For: Internists. 5-day Course, Apr 28-May 2, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neurosurgery

DIAGNOSIS OF A BRAIN TUMOR
For: MDs & Nurses. Lecture, Apr. 30, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Speaker:** L. Yarzagaray, MD, Asst. Prof/Neurosurgery, Loyola U. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Orthopedics

ORTHOPEDICS IN FAMILY PRACTICE
For: Family Practitioners. 1-day Course-Workshop, Apr. 16, 8:00 am—5:00 pm, Ann Arbor. **CME Credit:** 7 hrs. AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** R. K. Richards, Dir./Office of Intramural Ed., Towsley Center, U of M, Ann Arbor. MI 48104.

Pediatrics

ADVANCES IN NEONATOLOGY
For: Pediatricans. 2-day Course, Apr. 21-22, Chgo. **Fee:** $75. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med, 707 S. Wood St., Chgo. 60612.
RESIDENTS' COMPETITION
For: Pediatricians. Monthly Mtg., Apr. 15, Social Hr.—6:00 pm., Dinner—7:00 pm, Program— 8:00 pm, Mercy Hosp. & Med. Cntr., Chgo. **Fee** Dinner $12/ea. **Sponsor:** Chgo Pediatric Society, **Contact:** L. M. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.
SPECIALTY REVIEW COURSE IN PEDIATRICS
For: Pediatricians. 5½-day Course, Apr. 7-12, Chgo. **CME Credit:** 38 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Psychiatry

CHILD AND ADOLESCENT NORMAL DEVELOPMENT AND BEHAVIOR PROBLEMS
For: MDs. 5-day Course, Apr. 28-May 2, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
COMMON PSYCHIATRIC PROBLEMS OF CHILDHOOD
For: MDs. Short Course, Apr. 30, Indianapolis. **CME Credit:** 6 hrs., AMA Cat. 1, AAFP. **Fee:** $35. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U Sch./Med., 1100 W. Mich. Indianapolis, IN 46202.
MANIC-DEPRESSIVE ILLNESS: HISTORY OF A SYNDROME
For: Psychiatrists. Wkly. Seminar, Apr. 2, 9, 16, 23, 30,/5:00-6:30 pm. Chgo. **CME Credit** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601
PSYCHOANALYTIC PSYCHOLOY
For: Psychiatrists. Wkly. Seminar, Apr. 7, 14, 21, 28./6:30-8:00 pm. Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125 **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601.
THE RELATIONSHIP OF THEORY TO THE CLINICAL PRACTICE OF PSYCHOTHERAPY
For: Psychiatrists. Wkly. Seminar, Apr. 3, 10, 17, 24, 6:30-8:00 pm, Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Michigan Ave., Chgo. 60601.

Radiology

CHEST RADIOLOY
For: Radiologists. 3-day Workshop, Apr. 23-25, Indianapolis. **CME Credit:** 21 hrs., AMA Cat. 1, AAFP. **Fee:** $125. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U Sch/Md., 1100 W. Michigan, Indianapolis, IN 46202.
DIAGNOSTIC RADIOLOGY
For: MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Surgery

BLOOD VESSEL SURGERY
For: Surgeons. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $300. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day Course, Apr. 28-30, Chgo. **CME Credit:** 19½ hrs, AMA Cat. 1. **Fee:** $250. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
SURGICAL ANATOMICAL REVIEW
For: Surgical Residents. Month-Long Course, Ann Arbor. **CME Credit:** 105 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $300. **Sponsor, contact:** R. K. Richards, Dir., Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.
SURGERY OF GASTROINTESTINAL TRACT
For: Surgeons. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, Interns, 2-hr. Eve. Clinical Prog., Apr. 15, LaGrange Comm. Memorial Hosp., 5101 S. Willow Sprngs. Rd., La Grange, IL. **CME Credit:** 2 hrs., M Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons, 11255 W. 74th St., LaGrange, IL. 60525.

Allergy and Otitis Media

(Continued from page 43)

eustachian tubes, as well as environmental control from the allergy standpoint will often result in improvement. Environmental precautions regarding dust, molds, fur bearing animals and the other common allergens are recommended in these cases. This seems to be a good regimen even if an allergic origin has not been conclusively established. If the condition persists, or if there are recurrences, skin tests and hyposensitization are recommended. Treatment also has included myringotomy and insertion of polyethelene tubes, with a great deal of success. This most often requires a general anesthetic and does have occasional complications. Permanent perforations, cholesteatomas and chronically draining ears do rarely occur. We feel that patient medical management is indicated before resorting to surgical measures.

Summary

Chronic Secretory Otitis Media is one of the most common diseases of childhood and certainly not uncommon in adults. The condition is also probably an important factor in recurrent bouts of acute otitis media. Although there are other factors, being aware of its frequent relationship to allergy can be helpful in its treatment. ◄

References

1. Miglets, Andrew: "The Experimental Production of Allergic Middle Ear Effussion," *Laryngoscope* 9-73.

EKG of the Month

(Continued from page 42)

Answers: *1. E 2. C,D,E.* The rhythm strip shows high grade or severe AV block with an occasional sinus capture beat (2nd beat from the left). An occasional retrograde P wave is also seen (the inverted P wave following the third QRS from the left). The atrial rate is about 96/minute and the ventricular rate is about 38/minute. A ventricular focus (idioventricular rhythm) controls the ventricles for the most part. Quinidine or Pronestyl here could conceivably depress this ventricular focus and cause asystole and cardiac arrest. Therefore, the treatment here is a demand pacemaker. If signs of congestive heart failure persist after the ventricular rate is increased, then digitalis would be necessary. In this case increasing the ventricular rate to 75/minute eliminated all signs of heart failure. A His bundle recording localized the site of AV block below the bundle of His in the His-Purkinje system. ◄

Surgical Grand Rounds— Pancreatic Neoplasm

(Continued from page 46)

that died shortly following attempts at excision. These were also classified as malignant, although no pathologic evidence for this was found. As Dr. Olson said, there are six or seven cases that are diagnosed as nonfunctional islet tumor and I think they are probably examples of the same tumor in which there is a predominance of islet cell-like elements. This apparent hybridism between exocrine and endocrine elements is understandable since both islet and acini share a common embryologic anlage.

Dr. Beal: This has been a very interesting problem. The duration of symptoms in this 13-year-old girl is uncertain. She had been aware of the tumor for many months, but it did not cause her discomfort, with the mother finding it by chance. Review of the literature suggests that most children have had discomfort, but this child was free of any symptoms, other than the presence of the mass, that could be attributed to this neoplasm.

One of our concerns, of course, was the possibility of the necessity for a pancreaticoduodenal resection in this young child and the ultimate outlook with regard to growth and development. There are some instances of children who have had pancreatical duodenectomies for lesions of the pancreas and as far as one can determine from these reports, they do reasonably well if they survive the operation. Pancreaticoduodenectomy was necessary in this patient because this was the only way the tumor could be removed. The technique of a pancreatico-duodenectomy that we employed is essentially that described by Longmire in 1966. ◄

Bibliography

1. Frable, W. J., Still, W. J. S., and Kay, S.: "Carcinoma of the Pancreas, Infantile Type." *Cancer* 27, 667, 1971.
2. Longmire, W. P., Jr.: "The Technique of Pancreaticoduodenal Resection." *Surgery* 59, 344, 1966.

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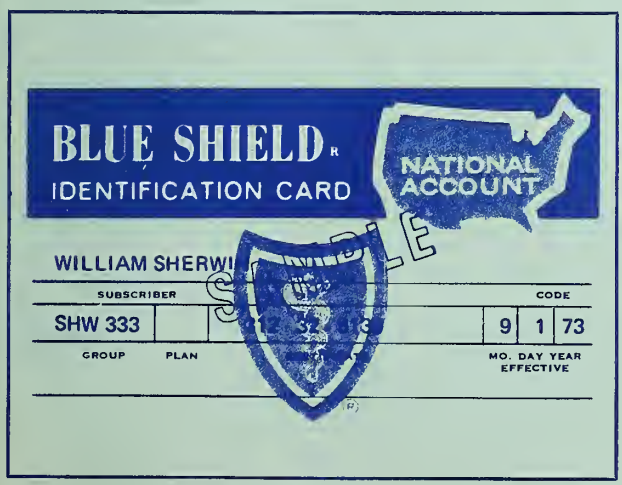
The Blue Shield Plan of Illinois Medical Service serves as the "Home Plan" for a number of national account groups in our Plan area. As a Participating Plan under our Central Certification system, we are part of a network whose primary function is to facilitate handling of claims for the national account groups.

These groups hold benefit contracts purchased by large corporations or organizations with branches throughout the United States that provide uniform insurance coverage to all their employees. Although the scope of benefits in the contracts may vary from group to group, *services provided locally are paid locally* by each Blue Shield Plan. Physicians, patients and groups are thus better served by the system of Central Certification.

National Membership Cards

Those enrolled in national account groups have membership cards with distinctive features. Cards differ principally in the wording. An example of a national account Membership Identification card is the one illustrated below, issued to Sherwin-Williams Company employees. Our Plan serves as the Home Plan for this company's program.

The significant feature of the card, in addition to the wording "Blue Shield Identification Card," is the outline map of the United States in the upper right portion—and "National Account" imprinted in the map.



Other national account membership identification cards may carry the wording "Blue Cross-Blue Shield Identification Card," but *all* have the outline map in the upper right quadrant with either "National Account" or "Central Certification" in the map portion. The name of the employer is generally printed prominently on the face of the card. Then follows the subscriber's name; a two or three letter Alpha Prefix; a three digit number and the employee's Social Security number: SHW 333/312-32-8139, as the ID card indicates.

The card shown appears in our new Medical Assistants' Handbook on page 4. There is also a discussion of Central Certification and a listing of the groups for whom we serve as the "Home Plan" on pages 66-67 for your information.

Completing the Physician's Service Report

When a service is furnished to a member enrolled in a national account group, use our Blue Shield Physician's Service Report for submitting the claim and enter *the Plan Number and employee's Social Security Number* exactly as it appears on the membership identification card. If the card is not readily available, please obtain this information before submitting the claim. Print or type the name of the patient and employee, double checking the spelling. A high percentage of claims are delayed because of errors in these two entries. Complete the Service Report in the usual manner and send it to us—Illinois Medical Service, 233 North Michigan Avenue, Chicago, Illinois 60601.

We have been requested by other Plans and several of our national accounts to ask your cooperation in following this procedure. We know we may expect your cooperation since it will facilitate processing claims and provide faster payment of benefits.

Revised Definition of Independent Laboratories

Federal regulations have been revised to modify the definition of an independent laboratory. Effective October 21, 1974, a physician's laboratory that accepts at least 100 specimens in a calendar year from other physicians for diagnostic tests in any specialty, must be certified by Medicare as an independent laboratory in all the specialities in which referrals are accepted for tests before payment can be made under the Medicare or Medicaid programs.

An SSA statement on the revision follows:

"In the past, a laboratory maintained by a physician to perform diagnostic tests primarily for his own patients did not have to meet Medicare and Medicaid laboratory standards, even though the laboratory performed some diagnostic tests on referral from other physicians. Because there were no volume limits prescribed on referral tests, there was continuous dispute as to whether the facility was or was not an independent laboratory.

"Under regulations issued by the Department of Health, Education and Welfare, effective October 21, 1974, a physician's laboratory accepting on referral from other physicians 100 or more specimens in any specialty in a calendar year must be certified as an independent laboratory in all specialties in which referral tests are accepted.

"For this purpose the specialties are: (1) Microbiology and Serology (2) Clinical chemistry (3) Immunohematology (4) Hematology (5) Pathology and (6) Radiobioassay.

"A physician's laboratory accepting 100 or more such referrals from other physicians in a calendar year, including both Medicare and non-Medicare patients, must be certified as an independent laboratory in order to be reimbursed by Medicare or Medicaid for the services.

"Any physician providing such referral services in the indicated volume in any of the designated specialties should contact the Medicare agency in his State Health Department to obtain certified status. In the near future, claims review procedures for payment of laboratory services will be reviewed so that physicians accepting specimens on referral will be readily identifiable.

"The new regulations were published in the Federal Register on September 19, 1974 and are incorporated in Section 405. 1310, Chapter 3, Title 20 of the Code of Federal Regulations."

Services performed in a physician's office for his own patients, or in a laboratory maintained by a number of physicians for conducting group practice, will continue to be covered as physicians' services and are not affected by the new regulations.

Changes in Filing Procedures On Combined Medicare-Medicaid Claims

The Illinois Department of Public Aid and Part B Medicare carriers (Blue Shield in Cook County) have adopted new procedures for submitting combined Medicare-Medicaid claims, effective January 2, 1975.

Physicians and other providers of Medicare and Medicaid services are requested to defer submitting combined claim forms SSA-1490, SSA-1491, SSA-1554 and SSA-1556 to the Illinois Department of Public Aid until the Medicare payment has been made, or notice of adjudication is received from the Part B carrier.

When the physician, or other provider, receives the Explanation of Medicare benefits form (EOMB), he should match it with the applicable claim(s), staple the items together and forward them to the Illinois Department of Public Aid in Springfield for payment processing.

The change in procedures is designed to reduce the processing time for combined Medicare-Medicaid claims by the Illinois Department of Public Aid and improve accountability for delayed claims. The IDPA will no longer adjudicate combined Medicare-Medicaid claims *unless the physician or other provider submits both documents* e.g. the SSA-1490 Request for Medicare payment form and Explanation of Medicare Benefits (EOMB), *attached together.* Unmatched documents will be returned, the Department advises.

Completion and submittal of the SSA-1490 Request for Medicare Payment forms to Part B Medicare carriers is unaffected by the new billing procedures. For Medicaid patients, however, the Department of Public Aid requests that physicians continue completing the item indicating acceptance of assignment and include the Illinois Department of Public Aid case identification number in the block labeled "Policy or Medical Assistance Number." Also the initial "IDPA" should be entered in the area provided for the signature of the patient, and Illinois Department of Public Aid specified in Item 5 of the SSA-1490 form.

SSA Change in Lab Certification

The Social Security Administration notified us of the withdrawal of the following laboratory from participation in the Medicare program:

LaGrange Medical Building Laboratory
47 South Sixth Street
LaGrange, Illinois 60525
Provider No: 14-8075

Services provided after January 1, 1975 are not covered.

IMJ

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IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

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Twenty-eight Clinics for Crippled Children Listed for March

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

March 6—Sterling—Sterling Community Hospital
March 6—Lake County Cardiac—Victory Memorial Hospital
March 10—Peoria Cardiac—St. Francis Children's Hospital
March 11—Carmi—Carmi Township Hospital
March 11—E. St. Louis—Christian Welfare Hospital
March 11—Peoria—St. Francis Children's Hospital
March 11—Carrollton—Boyd Memorial Hospital
March 12—Champaign-Urbana—McKinley Hospital
March 12—Hinsdale—Hinsdale Sanitarium
March 13—Macomb— McDonough District Hospital
March 13—Springfield—St. John's Hospital
March 14—Chicago Heights Cardiac—St. James Hospital
March 18—Belleville—St. Elizabeth's Hospital
March 18—Rock Island—Moline Public Hospital
March 18—Decatur—Decatur Memorial Hospital
March 19—Rockford—St. Anthony Hospital
March 19—Springfield Pediatric Neurology— Diocesan Center
March 19—Joliet—St. Joseph's Hospital
March 19—Evergreen Park—Little Company of Mary Hospital
March 20—West Frankfort—Union Hospital
March 20—Elmhurst Cardiac—Memorial Hospital of DuPage County
March 21—Chicago Heights Cardiac—St. James Hospital
March 24—Peoria Cardiac—St. Francis Children's Hospital
March 25—Alton—Alton Memorial Hospital
March 25—Peoria—St. Francis Children's Hospital
March 26—Centralia—St. Mary's Hospital
March 26—Chicago Heights—St. James Hospital
March 26—Elgin—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Role of the Detail Man

Opinion & Dialogue

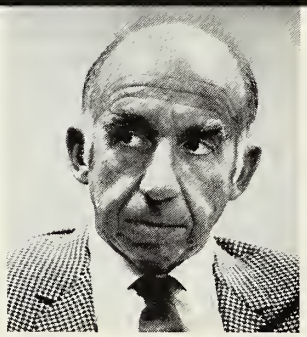


Dr. Willard Gobbell
Family Physician
Encino, California

"I may be prejudiced, but I am very much in favor of the detail men I meet. Most of them are knowledgeable about the drugs they promote and can be a great help in acquainting me with new medication."

Family Physician's Perception

I think that most general practitioners in this area feel as I do about the detail man. Over the years I have gotten to know most of the men who visit me regularly and they in turn have become aware of my particular interests and the nature of my practice. They, therefore, limit their discussion as much as possible to the areas of interest to me. Since I usually see the same representative again in future visits, it is in his best interest to supply me with the most honest, factual, as well as up-to-date information about his products.



Dr. Jeremiah Stamler
Chairman
Department of Community Health and Preventive Medicine, and Dingman Professor of Cardiology
Northwestern University Medical School

"In the total picture of dealing with health problems in this country, there is a potential for detail men to play a meaningful role."

The Positive Influence

My contact with representatives and salesmen of the pharmaceutical industry is the type of contact that people in a medical center, research people, and academic people have and that's in all likelihood on a somewhat different level from that of the practicing physician.

Let me touch on how I personally perceive the role of the sales representative. These men reach large numbers of health professionals. Thus they could be—and at times actually are—disseminators of useful information. They could consistently serve a real educational function in their ability to discuss their products.

At present they do distribute printed material, brochures and pamphlets—some of it scientifically sound and therefore truly useful—as well as some excellent films produced by the pharmaceutical industry. When they function in this

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

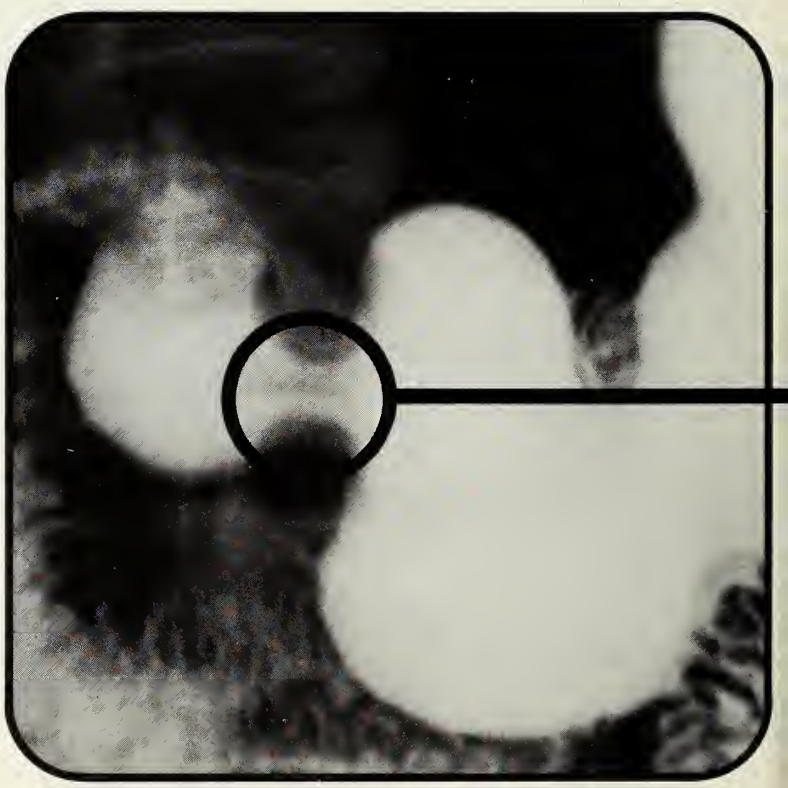
From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Upper functional G.I. disorders may be evidenced by epigastric pain

X-ray appears normal.



Editorials



Cancer Rehabilitation

Improved service for cancer patients under treatment—particularly those at home—as well as rehabilitation programs to improve the quality of survival, are of great importance in the cancer control effort.

Women who have undergone breast surgery, men or women whose voice boxes have been removed, or those who have had a colostomy, often undergo profound emotional shock. Their families often are dismayed, too.

It is here that volunteer agencies, such as the American Cancer Society, can bring aid and understanding to patients and their families.

"Reach-to-Recovery" is a program of the society for women who have had a mastectomy. After approval by the patient's doctor, a volunteer who has had breast surgery visits the woman as soon as possible in the hospital room. She brings visible assurance that recovery is possible. The patient's morale gets a tremendous boost when she realizes that she, too, can achieve normal appearance and resume former activities. Practical suggestions about exercise and clothing and other personal hints that aid readjustment result from such visits.

Many people who have lost their voices because of laryngeal cancer have learned a new method of speech through the International Assoication of Laryngectomees sponsored by the ACS.

Variously called "Lost Chord" clubs, or "New Voices," etc., member clubs of I.A.L. cooperate with physicians, speech therapists, and other specialists, helping patients develop new voices through esophageal speech.

The word ostomy denotes a type of surgery required when a person loses the normal function of the bowel or bladder, due to disease such as cancer or injury. A colostomy permits normal body functions through a new surgical opening in the abdominal wall, called a stoma.

The approximately 1,000,000 ostomates in the United States and Canada include children and adults from many different backgrounds and ethnic groups.

The United Ostomy Association, with which the American Cancer Society cooperates, conducts programs of information and volunteer-visiting to assist in the rehabilitation of persons who have undergone ostomy surgery.

All of these programs have grown from the concept of rehabilitation as a vital part of medical care.

T. R. Van Dellen, M.D.
Editor



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Alcoholism Recognition and Treatment Mandated

Several developments will coalesce or come into confluence as of July 1, 1975. These make it imperative that physicians in Illinois begin triage or treatment of alcoholics and alcohol abusers in all hospitals, as of July 1, 1975. The developments are as follows:

I. House Bill 629, of the 78th General Assembly, was signed in law September 11, 1973. All new and renewed health and hospital insurance being written in the State of Illinois subsequent to the date of enactment is mandated to cover health problems of alcoholism and alcohol abuse. This means that there will be private money available for the treatment of these people, as well as a certain amount of federal money.

II. Senate Bill 1674 (P.A. 78-1270) is effective July 1, 1975. This takes alcoholism and alcohol abuse out of the criminal justice system and puts it into an essentially medical milieu. The significance of this is that the police will no longer be arresting people on the basis of being drunk and hauling them off to the jail to the "drunk tank" to dry out. Instead, they will take them to another facility. This will be a hospital initially, for triage, and possible subsequent transfer to a detoxification center.

III. In the meantime, U.S. Public Law 93-282 prohibits discrimination in hospitals and other medical facilities against people who abuse alcohol. Penalties for disobedience to this law are very stiff. Specifically, facilities which discriminate against alcohol abusers will lose all forms of federal funding. Hospitals are sufficiently dependent on federal funds in one way or another that this loss would be a mighty blow.

In general, physicians are reasonably well informed of the chemical and physiological abnormalities which are produced by alcohol. However, there are also a number of areas in which they are not as up to date.

In view of the several above considerations, the Illinois State Medical Society is presenting a full day meeting for physicians during Convention '75, bringing them up to date on the management and treatment of the acute and the subsequent phases of alcohol abuse. All are invited.

"New Knowledge"

Second Special Report on Alcohol and Health to the U.S. Congress

This 219-page *Report* was prepared by a 38-member task force chaired by Morris E. Chafetz, M.D., Director of the National Institute on Alcohol Abuse and Alcoholism. It was transmitted to Congress by HEW Secretary Weinberger in November.

The NIAAA, which prepared the first comprehensive *Report on Alcohol and Health* in 1971, was established in May, 1971, under the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. Major amendments strengthening the Act were signed into law on May 14, 1974, by President Nixon, who also supported and signed the original measure.

Dr. Chafetz, in his introduction to the *Second Report,* says it "reflects the knowledge gained for the battle against the misuse of alcohol since the inception of the Institute. . . .

"Three years is miniscule in the long history of man's relation with alcohol," he said, "but these were years of notable progress. The energies and resources of a Nation were finally mobilized in concert among the Federal, State, local, private and volunteer sectors. What we have learned from this can, perhaps, be seen not only in a recitation of newly discovered facts, but also in terms of what has been accomplished and how understanding has developed.

"As an illness, alcoholism is devastating: the source of accidents and poor health; a contributor to the disruption of families; a well of human misery. Something is being done about it."

In Illinois, PA 78-767, recently enacted, mandates coverage for treatment of alcoholism in health insurance policies written in this state.

Findings

Findings of the *Second Special Report on Alcohol and Health,* summarized by the Institute include:

1. Alcoholism and alcohol abuse continue to occur at high incidence rates throughout American society.
2. The proportion of American youth who drink has been increasing so that, currently, it is almost universal. The highest scores on an index of possible problem-drinking behaviors were recorded in the youngest age group for which data are available, the 18-20 year olds.
3. The public suffers from much ignorance concerning alcohol and from ambivalent feelings toward it. Worse yet, heavier drinkers know less about alcohol than do lighter drinkers or abstainers. In general, American attitudes about drinking are marked by confusion and dissent.
4. The economic cost associated with misuse of alcohol is estimated at $25 billion a year. *(Illinois' estimated proportionate share of this cost is $1,750,000,000 annually, based on 900,000 residents in some stage of the alcoholisms.)*
5. The U.S. system of alcohol controls is a chaotic relic. It provides little support in mitigating alcohol problems and may induce a counterproductive ambivalence among the public.
6. The execssive use of alcohol, especially when combined with tobacco, has been implicated in the development of certain cancers. Non-white men appear to be especially susceptible.
7. Heavy drinking during pregnancy can adversely affect the offspring of alcoholic mothers. The significance of heredity in alcoholism is as yet unresolved.
8. Development of a new animal model of liver cirrhosis gives promise of resolving the problem of cause in one of the severest damages suffered by alcoholic people, and may contribute to more effective treatment and prevention.
9. Moderate consumption of alcohol is generally not harmful. In some cases, such as among the elderly, it may have beneficial physical, social or psychological effects.
10. Non-excessive use of alcohol does not appear to adversely affect the over-all mortality rate or the mortality from a specific major cause of death, coronary heart disease. In fact, the mortality of drinkers is lower than that of abstainers and ex-drinkers.
11. How alcohol intoxicates and how alcohol addiction develops are outstanding fundamental questions that require intensive research in several disciplines.
12. Alcoholism is a treatable illness, but different treatments are required by different individuals. Increasingly, individual treatment needs can be determined on the basis of valid studies or clinical experience.
13. Early identification and treatment are seriously constrained by the fact that the United States lacks a national consensus on what constitutes responsible use of alcohol. (Furthermore, the current lack of parameters with regard to comparatively safe versus unsafe drinking patterns provides an inadequate and ineffective clinical base for the diagnosis of alcoholism.)
14. Although the accessibility and quality of alcoholism treatment services are improving, there remains a serious deficit of such services, and only a small portion of alcoholic people are receiving the services required. Moreover, the bulk of treatment services which are available are designed to respond to late-stage alcoholism, and do not meet the needs of people whose alcoholism is identified at earlier stages of the illness.
15. Major strides can be made in providing adequate treatment for alcoholism with proper and efficient

utilization of resources and personnel. This requires continuation and expansion of the roles played by the private and voluntary sectors of society.

16. Treatment programs supported by business and industry can be especially effective in earlier identification of employees with alcohol problems, and such programs report the highest rate of recovery.
17. Third-party coverage for alcoholism treatment costs is essential, and feasible, to provide adequate services for all who require such treatment.

Recommendations

In response to the contents of the *Report,* the Secretary of Health, Education, and Welfare has recommended that:

1. The growing store of knowledge about alcohol and alcoholism be made more readily available for use by specialists and the public.
2. Educational resources for professionals and schools be expanded and developed.
3. Efforts to decriminalize and instead provide community care for alcoholism and public intoxication be redoubled. *(This is the intent of Illinois PA 78-1270 recently signed by the Governor.)*
4. New laws protecting the privacy and confidentiality of all citizens with drinking problems be strictly and immediately enforced.
5. Efforts be speeded up to assure quality care for and to reduce the carnage among Spanish speaking Americans, Indians and other native Americans, young Black men, and highway travelers.
6. The value of early identification and treatment programs in business and industry be generally recognized throughout the country.
7. Quality and comprehensive care be extended to alcoholic people through coverage under health and disability benefits and the establishment of standards for care. *(Recently enacted PA78-767 in Illinois.)*
8. New and revised policies and guidelines governing the distribution and sale of alcoholic beverages be developed.
9. It be recognized that the multiplicity and extent of alcohol-related problems cannot be the exclusive responsibility of the Federal Government. We must find ways to (a) strengthen the involvement and the role of private enterprise in reducing the problems of alcohol abuse and alcoholism; and to (b) enhance the role of and support by State and local governments and voluntary agencies of activities related to the care of the afflicted and in their contribution to preventive efforts.
10. Efforts be made to intensify the study of the relation of alcohol use to cancer, heart disease, liver disorders, pregnancy and fetal health, aging, longevity and mortality, and brain function and the addictive process.
11. A new national consensus concerning what constitutes responsible use and non-use of alcoholic beverages be formulated and articulated. ◄

Implementation of the Illinois Alcoholism and Intoxication Treatment Act (P.A. 78-1270) by the Health Care Professions

By George W. Erdmann, Deputy Alcoholism Program Advisor, IDMHDD

It is unrealistic to believe that enactment of PA 1270 into law (effective July 1, 1975) will not require some significant changes in present procedures and modalities generally utilized for identifying and managing persons who experience various degrees and frequencies of alcohol intoxication and are in some phase of the multistage alcoholisms. Were it not for the strong concensus of federal and state legislators, and of prevention and treatment authorities in many different, involved disciplines, that traditional practices for dealing with the epidemic problems of abusive use of beverage alcohol no longer are acceptable, extensive federal legislation and the Acts of twenty-three states would not have been passed.

While this body of legislation, originally spearheaded by passage of Federal PL91-616 in 1970, is not without some imperfections, various federal and state laws enacted in the last four years represent a new awakening, a far more enlightened approach.

In view of historical attitudes toward both alcoholism and persons having various stages of cern that Illinois health care systems cannot presently accommodate all the demands statutorily required. This concern is entirely valid.

However, by carefully planned organization and marshalling of resources, each Illinois community can effect massive improvement in its present provisions for prevention and treatment service to its population directly and indirectly suffering the consequences of alcohol abuse, alcoholism and intoxication. These are conditions seriously affecting the physical and mental health of our communities, and history makes it abundantly clear it is not within the province of criminal justice systems either to treat or to rehabilitate. The multiple manifestations and causes of abusive use of alcohol find remission and maintenance of remission only in the multi-disciplinary services of *health care systems.*

Emphasis is placed on systems. No one modality either need, can, nor may carry a dominant portion of the task. But when prevention and treatment is coordinated and intralinked through the continuum services of a multi-disciplinary network system, extremely gratifying results are attainable and the intent of the legislation can be realized.

The New Role of Law Enforcement

Illinois has over 800 separate law enforcement bodies with 24,000 officers. The Chicago Police Department alone has about 13,000 officers who each year identify, arrest and transport some 50,000 publicly intoxicated persons and 20,000 alcohol impaired persons to holding facilities pending arraignment and processing by the criminal justice system. By provisions of PA 1270, those persons not charged with any offense other than public intoxication, are to be proferred assistance by the police. Most will be transported to an approved facility for medical evaluation, as provided in the bill.

The police officer is *not* a diagnostician. Rather than arrest and incarcerate, the procedure now becomes identify and *assist to qualified treatment.* However, when a violation of law is alleged to have occurred, the intoxicated person remains subject to due process. The significant new differences are that simple public intoxication, *per se,* no longer is a criminal offense and such persons shall be afforded treatment for their illness. Those intoxicated or alcohol impaired persons who have been charged with a violation of law, in addition to being subject to due process, also shall be afforded treatment for their illness which preponderantly is the primary cause of the maladaptive and illicit behavior.

Role of the Approved Medical Facility

The new state law, and federal legislation (PL93-282) mandate that publicly intoxicated persons and those impaired by excessive ingestion of alcohol be afforded non-discriminatory medical treatment. This service will be provided initially by the emergency department of a hospital. Since October, 1969, hospitals have been required by PA76-1858 to render emergency medical services to all persons presented whose condition is liable to cause death, serious injury or serious illness . . . criteria applicable to the unremitted and progressive syndromes of the alcoholisms.

For the majority of alcohol intoxicated or impaired persons presented to emergency departments, no treatment is required other than simple medical triage and firm referral to a non-medical agency of the community alcoholism network system.

Assuming, for example, that the experience of the Ontario Addiction Research Foundation (with some 30,000 cases processed under their Treatment Act) is replicatd in Chicago, 5% of intoxicated persons presented to emergency departments will require Emergency Medical Services (EMS) in addition to simple triage. Based upon the present approximate 50,000 Chicago arrests for public intoxication, this would result in 2,500 incidents annually requiring specific hospital treatment. The other 95%, or 47,500, would be referred to community network system agencies for short term rehabilitation and subsequent continuum treatment services.

Role of the Community Alcoholism Network System Agencies

The hospital, trained staff, and specialized facilities are a vital part of the total prevention and treatment network system. It is *not* the entire system and, in fact, will deliver specialized services only to a small percentage of those alcohol incapacitated and impaired persons presented to it. Detoxification, rehabilitation, continuum services and remission maintenance responsibility falls upon other components of the alcoholism community network system. These other component agencies include detoxication centers; transitional resident modalities such as quarter, half-way, and three-quarter way agencies; structured and non-structured outpatient services; volunteer agencies such as Alcoholics Anonymous, Al-Anon Family Groups, Alateen; occupational alcoholism programs and several ancillary services, *i.e.,* Department of Public Aid, Department of Corrections, Division of Vocational Rehabilitation, etc.

There can be no illusion that alcohol abuse, alcoholism and intoxication legislation enacted in the last four years by federal and state governments does not articulate significant change in society's attitude toward its number one health problem . . . the alcoholisms ("Alcohol and Health", H.E.W., December, 1971). Nor can there be any doubt that this growing change in the understanding and attitude of today's society regarding this illness demands equivalent responses from the health care system. This response clearly must include departures from the historical procedures of arrest and incarcerate and from the customary attitudes and modalities concerning prevention and treatment.

The community network *system* holds the potential for meeting these demands, to which no single modality can be adequately responsive. It has the potential for permitting the prevention and treatment disciplines to respond meaningfully to society's growing awareness of a need for enlightened attitudes, procedures and practices of treatment continuums to replace the punitive, non-productive procedures of the criminal justice system. ◄

(Important note on page 136)

Drugs and Fatality Levels Found in Overdose Cases

By George N. Christopoulos, Ph.D., Andrew J. Toman, M.D., and Robert J. Stein, M.D./Chicago

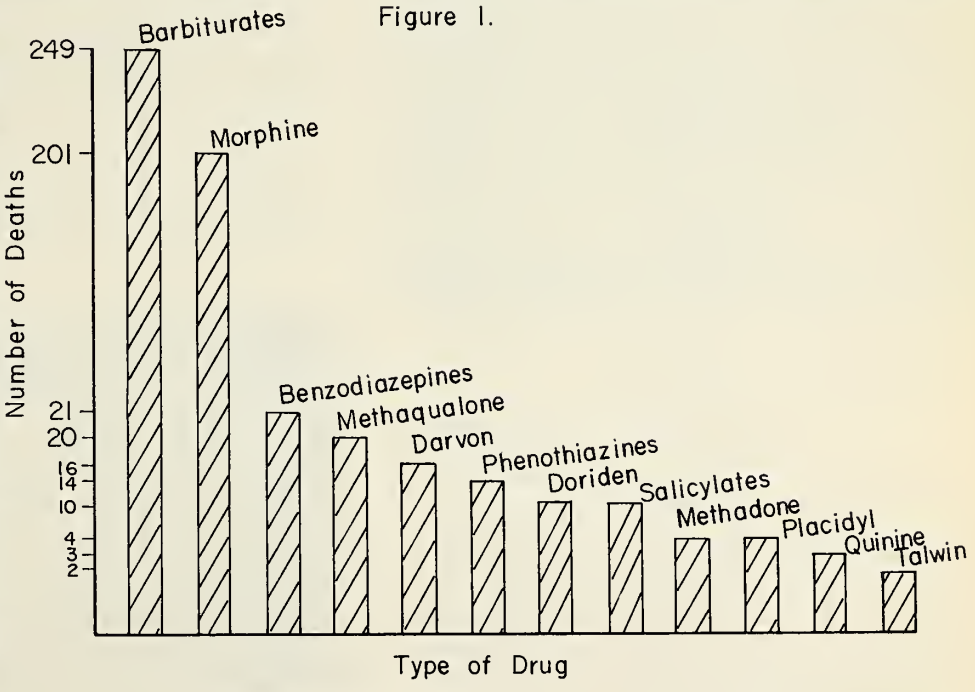
Information regarding fatality levels of certain poisons found in postmortem tissues and fluids is very limited. We will express our opinion, with several references as to the fatality levels of drugs found in postmortem specimens. Furthermore, we will attempt to inform physicians in Illinois of the most common drugs found in overdose cases.

Forensic toxicologists and pathologists face a real problem in interpreting toxicological findings. Reference material on which such decisions must be founded is not always readily accessible. Each case has to be examined individually, because there are many problems connected with obtaining an adequate and thorough investigation of even fatal poisonings. Some problems encountered are: insufficient clinical history, presence of multiple toxic substances, inadequate or improperly obtained and preserved samples, specimens from embalmed body, no autopsy and so on . . .

With fatalities it cannot be emphasized too strongly that an autopsy is not only desired but essential, if death by poisoning is to be established. In the absence of an autopsy or an enlightening medical history, it is difficult to determine how the amount of a specific drug in a person might be interpreted.

With all drugs, individual variances will have a profound effect on the interpretation of drug concentrations. Many drugs cause irreversible damage when their concentration in the blood is high, but if the person dies later, the concentration at the time of death may be much lower. Death may result when two or more drugs are each present in sublethal amounts. The types of analyses that may be performed and the specimens that are desired for analysis vary from laboratory to laboratory, depending upon the expertise of the analyst, the availability of equipment, and the workload of the laboratory. Drugs that may be determined when present in lethal

Figure 1.



The authors are from the Toxicology Laboratories, Institute of Forensic Medicine, Cook County Coroner's office, 1828 West Polk Street, Chicago, Illinois 60612.

amounts may be infinitely more difficult or impossible to find in therapeutic amounts. Liver tissue and large volumes of blood may be obtained from the dead, whereas in the living, only urine or a small amount of blood may be available.

Opinions we offer are based on present information. As more information becomes available, it is certain that some opinions will have to be changed.

Barbiturates

Barbiturates, sedative hypnotic drugs, have their primary action on the nervous tissue. Consequences of this primary action are manifested as hypnosis and anesthesia, anticonvulsant effects, and miscellaneous effects such as analgesia, autonomic reactions, and respiratory effects, among others.

As in Figure 1, there were 249 deaths in the year 1973 involving barbiturates. The most common barbiturates found were Phenobarbital (79 cases), Tuinal (Amobarbital-Seconal) (70 cases), Secobarbital (47 cases), Pentobarbital (22 cases), Amobarbital (12 cases), Butabarbital (9 cases) and Thiopental (8cases).

Forty-three of the above cases were involved in violent deaths (gunshot and stabbing victims). Eight cases contained Thiopental which is an ultra-short-acting barbiturate used in anesthesia. The eight Thiopental cases were post-surgical deaths with very questionable levels of Thiopental.

The following range of concentrations of barbiturates in blood are considered fatal by us:

Table 1

	Barbiturate alone in mg%	Barbiturate and Ethanol in mg%
Secobarbital	1.0 — 2.5	0.5 — 1.0
Pentobarbital	1.0 — 2.5	0.7 — 1.2
Amobarbital	3.0 — 6.0	1.5 — 3.5
Tuinal	2.0 — 3.5	1.5 — 3.0
Butabarbital	3.5 — 6.0	2.5 — 3.5
Phenobarbital	8.0 — 12.0	4.0 — 6.0
Thiopental	0.5 — 1.0	— — —

Our ranges are in general agreement with other studies[1,2]. Oral doses of 600 mg of barbiturate produce the following average maximum concentrations in blood:

Phenobarbital 0.33mg%; Secobarbital 0.48mg%; Amobarbital 0.96mg%; Butabarbital 0.14mg% and Phenobarbital 0.23mg%[3].

Methaqualone

Methaqualone, a relatively new hypnotic, is similar in action to barbiturates, and seems to be the most popular misused drug in Cook County.[4] Methaqualone was found as the cause of death in twenty cases in 1973. Fatality levels of Methaqualone range between 0.5 — 1.5 mg% in blood, 0.6 — 1.8 mg% in liver, and with the highest concentration in the bile ranging between 6.0 mg% to 10.0 mg%.

Glutethimide (Doriden)

Doriden is a sedative hypnotic drug whose actions are similar to an intermediate type of barbiturate.

Ten deaths resulted from Doriden overdose in 1973. The range fatality levels in blood is between 1.5 — 3.0 mg%, with higher concentrations in liver, brain and kidney.

Ethchlorynol (Placidyl)

A sedative hypnotic drug, not very popular; however, four deaths were directly attributed to Placidyl intoxication in 1973. Fatality levels range in the area of 2.0 — 5.0 mg% in blood, and higher in liver and brain.

Figure 2 shows some sedative hypnotic drugs found in the victims' posession.



Figure 2. Drugs found in possession of a victim (Seconal, Tuinal, Darvon, Dilantin, and Meprobamate).



Figure 3. Several of the addicts' tools for injection.

Morphine

Morphine, which medically has been used extensively for many years, remains the most important narcotic analgesic. The respiratory center is markedly depressed by morphine, and stoppage of respiration is the cause of death in morphine poisoning. The source of morphine found in post-mortem tissues is believed to be mostly from Heroin (Diacetylmorphine) which is very rapidly metabolized to morphine in the body.

As in Figure 1, there were 201 deaths in 1973 involving morphine. Of these 48 were gunshot wounds, and four were stabbing victims. In Figure 3, one can see several of the addicts' injection kits. Figure 4 shows Mexican heroin (brown) found in the victims' rectum after the victim had been shot.

The fatality level of Morphine is between 3.0 – 6.0 mg% in bile[5]. However, if taken with alcohol and a barbiturate, the range is lower. The trend of Heroin diluents in 1973 was mostly Procaine and Phenobarbital. Penobarbital prolongs withdrawal in the addict, but the combination can be deadly. Quinine also is used as a diluent, but sometimes a pusher sells quinine alone, and three deaths have been attributed to quinine.

Pentazocine (Talwin)

Pentazocine actually is a weak narcoitic antagonist with a significant analgesic effect of its own. Its potency is moderate and of short duration, but its low addiction liability makes it useful in chronic illness in which more addictive drugs would consitute a hazard. Two deaths were attributed to Pentazocine overdose in 1973. The lethal range in bile is 2.0 – 5.0 mg%, and 1.0 – 2.0 mg% in liver.

Methadone

The analgesic potency of Methadone is about as great as that of Morphine, but is of longer duration. As a consequence it is administered in doses of 10 mg., and is quite effective following oral administration. It causes considerable respiratory depression, but its emetic and constipating actions are less than those of Morphine. Development of tolerance and addiction to Methadone are known to occur. Sedation and euphoria are slight. A unique application of Methadone is in the treatment of morphine addiction. If the drug can be substituted for morphine, subsequent withdrawal will be less severe, but may be more prolonged.

Methadone has come into the picture after Methadone clinics in our state were formed.

Four deaths were attributed to Methadone overdoses in Cook County last year, but from projections into 1974, the number of deaths is rapidly increasing and this is perhaps in contradiction to the claims that Methadone is relatively safe.



Figure 4. 6.0 gms of 39% Mexican Heroin, and 5.0 gms of Procaine, found in rectum of gunshot victim.

Propoxyphene (Darvon)

Propoxyphene is related to Methadone, but has much lower potency and addiction liability. It is widely used, often in combination with aspirin, phenacetin, and caffeine, the so-called Darvon compound. It is commonly stated that its analgesic potency is similar to that of codeine, but this is doubtful. Pure Propoxyphene is a weaker analgesic than Codeine.

Sixteen deaths were attributed to Darvon, with salicylates and caffeine also being present.

The range of Propoxyphene in blood is very low in fatalities, 0.3 — 0.9 mg%. Often it presents a problem in interpreting the fatality levels due to a mixture with salicylates and ethanol.

Benzodiazepines (Librium, Valium, Dalmane)

The Benzodiazepines are widely used anti-anxiety drugs having central and skeletal muscle relaxing properties. The pharmacology of the Benzodiazepines is basically similar to that of the barbiturate hypnotic, except that in some tests they can achieve effects without excessive sedation or ataxia.

Librium and Valium are very popular minor tranquilizers and with Dalmane, used as a hypnotic, together have contributed to 21 deaths.

The fatality levels range between 0.5 — 1.0 mg% in blood, and very often there are multiple drug findings or ethanol.

Phenothiazines

The first widely used Phenothiazine tranquilizer was synthesized in France in 1950. The potent tranquilizing and antiemetic actions of chloropromazine led to widespread use of the drug in various fields of medicine. Subsequently, many other Phenothiazine tranquilizers were synthesized. At present there are at least twelve of these in clinical use.

The pharmacological effects of the Phenothiazine tranquilizers are quite complex. In addition to their activity on behavior, these drugs are potent antiemetics and have important actions on the autonomic system at various levels. In large doses they also produce significant toxic side effects such as Parkinson-like symptoms.

Phenothiazines were found in fourteen cases with Thioridazine (Mellaril) the most popular. The range of concentrations in our fatal cases is between 0.5 — 1.5 mg% in blood and 1.0 —2.0 mg% in liver.

Stimulants

Imipiramine, Amitriptyline and amphetamines have contributed to some deaths, but such stimulants and anorexics were found to have caused only five deaths. Fatality levels range from 0.5 — 1.0 mg% in blood for amphetamines, and for the Dibenzazepine group from 0.5 — 1.5 mg% in blood.

Miscellaneous Poisons

Salicylates, Fluoroaluanes (Freons), Toluene, Benzene, and hexanes (glue sniffing) contributed to several deaths. Ten were salicylate poisonings with a range of 20-30 mg% in blood, and three were glue sniffing deaths.

Summary and Conclusions

We have attempted to give some information on the current drug problem facing Cook County. Some of the information given is in agreement with some individual publications on certain medicinals.[6-9] Total data have not yet been compiled for 1974, but initial findings indicate a worsening situation. ◄

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Implementation of PA 78-1270
(Continued from page 131)

The foregoing summary by Mr. Erdmann of the explicit and implicit intents of PL91-616, PL93-282, PA78-767, PA76-1858, PA78-1270, and the "Illinois State Plan for the Prevention, Treatment and Control of Alcohol Abuse and Alcoholism," is not to be construed as a substitute for the text, illustrations, and definitions of these documents. Should you have need of assistance or would like copies of these laws, please contact your Regional Alcoholism Coordinator in the Department of Mental Health and Developmental Disabilities.

Barbiturate Misuse and Abuse
A Medical-Historical Perspective

By Richard M. Krieg, M.A., and Paul Buchholz, M.S.W./Chicago

The federal drug abuse initiative of the past decade has been predicated on the tremendous "social cost" of drug abuse within the United States. Public awareness of the relationship between heroin addiction and crime spurred the development of complex drug abuse service delivery systems in large urban centers across the country. The evolving national drug abuse perspective, as revealed in the federal allocation system and resultant statewide drug abuse strategies, was attuned to the eradication of societal problems engendered by drug abuse. As a determinant of funding priorities, the "social cost" of drug abuse was viewed primarily as the cost to society, as opposed to costs incurred by the individuals abusing drugs. In this light, the war against drug abuse became identified with the highly visible efforts to respond to heroin addiction and, secondarily, to adolescent polydrug abuse.

During the late 60's, the issue of a "hidden drug problem" in America surfaced. In 1971, it was reported that 25% of all American women over the age of thirty had regularly received prescriptions for barbiturates, tranquilizers, or amphetamines.[1] The American Medical Association's Committee on Alcoholism and Drug Dependence (1968) found that people who abused barbiturates mainly were middle-aged and older persons, "the types not often found abusing other kinds of drugs. Most misusers of barbiturates who become dependent are individuals who find life's tensions and anxieties unbearable.

"Similar to alcoholics, they need the feeling of security and well-being they believe their drug will give them."[2] Barbiturate abusers, many of whom relied on legally prescribed drugs, practiced their abuse in the privacy of their home without causing disturbances in the community. Evidence mounted that, for the first time, a sizable number of adolescents were represented among the barbiturate abusing population. In 1969, the Subcommittee on Juvenile Delinquency of the U.S. Senate Judiciary Committee reported that "there is now no generation gap in the abuse of barbiturates. Production of barbiturates is enough to provide each man, woman, and child in the land with fifty doses. At least half of this supply gets into the illicit market."[3]

Other patterns of barbiturate abuse became apparent. Barbiturates have been used as a temporary substitute for heroin during times of scarcity, as well as in conjunction with alcohol, LSD, and amphetamine usage. In unusual cases, barbiturates were taken for exhilaration and for a sense of increased efficiency. This can happen after tolerance develops through prolonged usage, since the drug can have a stimulating rather than a depressing effect.[4] The American Medical Association reported that the fatality potential for barbiturate abusers is extremely high and that withdrawal, without supervision, can be fatal. "With narcotics, suicide from overdose is rare because increasing tolerance raises the lethal limit. This limit is not raised significantly by barbiturate tolerance."[5]

The Illinois State Plan for Drug Abuse Programs revealed that although heroin abuse accounted for most drug related deaths in Illinois during 1970, in 1971 statewide, and in 1972 in Cook County, barbiturates had assumed prominence as the major cause of drug related deaths.[6] The Cook County Coronor's Office has indicated that drug overdose deaths during the first nine months of 1974 were 100% higher than during the same period of 1973.[7] The American Medical Association recently suggested that physicians must maintain and strengthen their roles in assuring the proper use of sedatives in the face of increasing production. The current production of all sedative drugs exceeds legitimate medical needs by a considerable margin.[8] At the present

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The Dangerous Drugs Commission, Illinois' Single Stote Agency far Drug Abuse, is responsible for state-wide drug abuse planning, coordination, and odministration.

Chronology of Research on Barbiturate Use

Researcher	Date	Publication	Results
Curran	1938	*American Journal of Psychiatry*	Recommendation of gastric lavage for severe acute barbiturate intoxication.
Kalinowsky	1942	*Archives of Neurology and Psychiatry*	Discussion of the possible relationship between alcohol delirium and seizures and the analogous manifestations in intoxication with barbiturates.
Hewitt	1950	*Journal of Nervous and Mental Disease*	A psychosis of a toxic type occurring during barbiturate withdrawal is described.
Isbell	1950	*Archives of Neurology and Psychiatry*	Chronic barbiturate intoxication and withdrawal is discussed.
Isbell	1950	*Annals of Internal Medicine*	The withdrawal syndrome is discussed, and chronic barbiturate intoxication is called a true addiction.
Nyswander	1950	*New England Journal of Medicine*	First indication of a relationship between heroin and barbiturate abuse.
Isbell	1951	*Postgraduate Medicine*	Need for rehabilitative therapy following barbiturate withdrawal is discussed.
Morgan	1952	*Journal of the American Medical Association*	Many physicians erroneously think of the syndrome as one of barbiturates toxicity rather than as a withdrawal syndrome.
Fraser	1953	*American Journal of Medicine*	Barbiturate withdrawal must be accomplished very slowly, with gradually decreasing doses and constant patient supervision.
Fraser	1954	*Archives of Internal Medicine*	Characteristics of the barbiturate abstinence syndrome are discussed.
Fraser	1954	*Journal of Pharmacology and Experimental Therapeutics*	The abstinence syndrome is discussed in terms of chronic secobarbital, amobarbital, and sodium barbital intoxication in dogs.
Fraser, Isbell, Fisenman	1954	*Archives of Internal Medicine*	Chronic barbiturate intoxication was studied in 19 opiate addicts. Results of psychological, electroencephalographic, and biochemical studies are reported.
Sainz	1957	*Psychiatric Quarterly*	Although definite conclusions could not be reached, chlorpromazine was viewed as the drug of choice in barbiturate detoxification.
Ewing	1958	*American Practitioner and Digest of Treatment*	A case is reported in which psychologic and physiologic dependence upon meprobamate developed.
Essig	1958	*Electroencephalographic and Clinical Neurology*	Electroencephalographic changes in man during use and withdrawal of barbiturates in moderate dosage were studied.
Blachly	1964	*American Journal of Psychiatry*	A procedure for barbiturate withdrawal is outlined. Psychotherapy during withdrawal is of little value, but a firm supportive relationship is necessary.
Jaffe	1965	*Journal of Pharmacology and Experimental Therapeutics*	Thresholds for Pentylenetetrazol-induced seizures were determined in cats after varying periods of deep barbiturate intoxication.
Essig, Fraser	1966	*Clinical Pharmacology and Therapeutics*	Animal study, testing the effects of Chlorpromazine at various levels of barbital withdrawal; indicated that the drug failed to suppress convulsions or restlessness.
Glatt	1967	*British Medical Journal*	Barbiturates are the most widely used agent in nonfatal attempts at suicide.
Gardner	1967	*Lancet*	Four instances of fits occurring as part of barbiturate withdrawal symptoms are cited. Three of the patients had been diagnosed as cases of epilepsy and received supplies of their addictive drug.

Researcher	Date	Publication	Results
Cumberlidge	1968	*Canadian Medical Association Journal*	Comparison of heroin and barbiturate abuse; barbiturate addiction is markedly more dangerous to the addict than heroin addiction, particularly in terms of lethal dose and withdrawal symptoms.
Cumberlidge	1968	*Canadian Medical Association Journal*	Heroin addicts report use of barbiturates to potentiate the action of heroin, reduce awareness of heroin withdrawal symptoms, and alleviate personality and interpersonal relationship problems.
Moravec	1969	*Hospital Management*	The fast pace of the times has resulted in a population that lends itself to addiction and overdose. Barbiturate addiction is more serious than morphine addiction, because it presents a more widespread public health and medical problem.
Buckley	1969	*Journal of Allergy*	Unexplained dermatitis following intercurrent infections were traced to drug intoxication.
Wurmer, Spiro	1969	*Modern Treatment*	Barbiturates cannot be withdrawn too quickly.
Norton	1970	*Journal of Pharmacy and Pharmacology*	The effects of drugs on barbitone withdrawal convulsions in rats is examined.
Gay, Wesson, Smith	1972	*International Journal of the Addictions*	The phenobarbital substitution technique for outpatient barbiturate withdrawal is explained.
Ronse, Vervarcke	1972	*Psychiatric Belgica*	Five drug addict patients who suffered epileptic seizures and who represented themselves falsely as epileptics in search of treatment are described.
	1972	*U.S. News and World Report*	Barbiturates may surpass heroin as the most commonly abused dangerous drug among youth.
Swartz	1972	*Texas Medicine*	A complete review of the chemical and physical properties of barbiturates is conducted.
Bleyer, Marshall	1972	*Journal of the American Medical Association*	A case is reported of congenital barbiturate addiction in a child. The infant suffered acute episodes of seizures and severe central nervous hyperirritability during the immediate neonatal period and again at the age of four months.
Glasscote, Sussex, Jaffe	1972	*Treatment of Drug Abuse*	Communities with available detoxification resources will save lives in barbiturate withdrawal.
No Author	1972	*British Medical Journal*	Clinical features related to barbiturate withdrawal in infants of mothers who took barbiturates throughout pregnancy or its last trimester.

time, the ISMS Committee on Alcoholism and Drug Dependence, in conjunction with the Dangerous Drugs Commission, are jointly exploring the extent and nature of this problem in Illinois.

Historical Usage

Introduction of barbiturates into medicine represented a marked improvement over drugs previously prescribed for insomnia and anxiety. Bromide Salts, which did not share the objectionable qualities of paraldahyde and chloralhydrate, lost prominence during the late 19th century due to publicized reports of widespread chronic bromide poisonings.

Recognized advantages of the early barbiturates were their tasteless character and the fact that precise quantities could be dispensed orally. Vital to the treatment of epilepsy, the efficacy of barbiturates for the management of anxieties, high blood pressure, and peptic ulcer quickly became apparent. Barbitol, the first barbituric acid derivative, was synthesized by von Mering and Fischer in 1903, and marketed under the trade name of Veronal. Phenobarbitol was introduced into general medical practice in 1913. Despite the subsequent synthesis of thousands of barbiturates, only a relatively small number have enjoyed common clinical usage.

During the 1940's, a rising barbiturate black market, prompted by the labelling of sedative hypnotics as "thrill pills," began to fluorish. As early as 1937, the American Medical Association

attributed habit formation to barbiturates and cited the substitution of pills for alcohol and the use of drugs in suicide.[9] Also during the 1940's, as production of barbiturates tripled, so did deaths due to barbiturate overdose.[10] Half of these deaths were accidental and approximately half were suicidal. By 1949, nearly one quarter of all poisoning cases admitted to American hospitals were due to acute barbiturate intoxication.[11] The ascendency of barbiturates as a major drug of abuse grew even more pronounced during and after the 1950's. It is fortunate, however, that medical research mounted during this period provided insight to the nature of this growing problem. The tabular chronology traces the significant steps in development of medical understanding of barbiturate abuse.

In order to view the misuse of barbiturates from a realistic perspective, it is essential to construct an adequate definition for barbiturate abuse. Wesson, Gay, and Smith (1972), pointed out that "the common practice of equating all non-medically supervised use of barbiturates with abuse is ineffectual and has led to much of the confusion concerning the severity and magnitude of barbiturate abuse."[12] Different patterns of non-prescribed barbiturate use each imply distinct risks. Risks inherent in occasional, non-prescribed barbiturate use for insomnia, for example, are entirely different than those of an adolescent injecting barbiturates intravenously. Abuse of barbiturates is usually defined as self-prescribed medication to the extent that harm occurs to the individual or to society. Smith (et al) points out that "this interpretation separates use and abuse on the basis of consequences. One of the difficulties with this definition is that it does not take into consideration the pattern of barbiturate use. An allergic reaction or an automobile or industrial accident following a single self-prescribed dosage of barbiturates would be defined as abuse, whereas chronic usage even of doses beyond the therapeutic range without adverse consequences would not." Thus, the most useful method for conceptualizing non-medical barbiturate usage has resided in determining models, or patterns, of barbiturate abuse.

Patterns of Non-Medical Barbiturate Use

Major categories of barbiturate abuse, highlighted by the National Institute on Drug Abuse (NIDA), are chronic intoxication, episodic intoxication, and intravenous barbiturate use.[13] The more common pattern of occasional, non-prescribed pill usage for insomnia is not included in the NIDA categorization, since it approximates prescribed medical usage.

Chronic Intoxication

Some individuals are prone to overuse any drug which will lessen worries or anxieties. The intent of their drug usage is to maintain an anxiety-free state. These individuals generally are in the 30 to 50 year age group, and are likely to be introduced to barbiturates in the form of "mild tranquilizers" or "sleeping pills." Most of these individuals are of the middle or upper socio-economic class, and have no identification with youthful drug using subcultures. They find that barbiturates make coping with life easier, and as tolerance to the tranquilizing and sedative effects develops, they increase their dose—often without their physician's knowledge. It is this tendency to escalate dosage without medical advice which distinguishes these individuals from those who properly use sedatives to combat excessive anxiety or stress. As daily dosage increases, they usually begin contacting other physicians and requesting barbiturates for treatment of sleeping difficulty or of nervousness. Often several physicians end up prescribing for these patients simultaneously. None of the physicians involved may be aware that the patient is abusing barbiturates prescribed. Also, because of a conventional middle class appearance, pharmacists are more likely to refill prescriptions without notifying the physician.

These individuals often are unidentified for some time, until confusion, irritability, decreased ability to work, and episodes of acute intoxication with slurred speech and staggering gait, finally draw attention to their drug usage. Physical dependence may be marked by the time such misuse is discovered. Frequently, also, there is a history of alcohol misuse, often in conjunction with the barbiturates. In these individuals, overdose due to confusion, loss of memory and repeated doses, is a major medical hazard, and industrial and motor vehicle accidents are a common danger.

This is the "hidden" pattern of barbiturate abuse in America; however, no one really knows how many individuals are involved. At present there is virtually no hard data concerning the extent or severity of chronic sedative-hypnotic intoxication among the middle and upper classes in this country. There are indications that the problem is large and is growing, but by its very nature defining the scope of hidden barbiturate abuse is almost impossible.

Episodic Intoxication

An episodic pattern is most commonly seen in teenagers and young adults. Sufficient amounts of barbiturates (100 to 300 mg) are taken orally to produce a "high" or disinhibition intoxication, in much the same manner others use alcohol. The sources of supply for these individuals are the black market, the family medicine cabinet and, occasionally, prescriptions. Primary difficulties associated with this pattern of use are accidental overdose, escalating involvement with drugs of many pharmacological varieties, and the same dangers inherent with teenage alcohol intoxication, that is, poor coordination, risk taking, and irrational behavior.

Intravenous Barbiturate Use

Barbiturate capsules can be dissolved in water and injected. This pattern usually is seen in young adults who have a strong commitment to the drug using subculture. Many of them have "graduated" from multiple "pill popping," episodic intravenous amphetamine use, or occasional heroin use. Barbiturates are injected primarily for the "rush" effect, an intensely pleasurable warm and drowsy feeling of abrupt onset, experienced immediately after injection. A "rush" is obtained only by injection and is not experienced following oral ingestion. While this usage probably involves a relatively small number of individuals compared with the other patterns described, it is by far the most hazardous use. The individual rapidly develops a tolerance to the intoxicating qualities of barbiturates and subsequently increases the dose. Tolerance to the fatal dose, however, does not increase as much as tolerance to the intoxicating dose. The misuser is thus exposed to a much greater chance of accidental overdose, with possible respiratory arrest and death. Also, there are the dangers inherent in non-medical needle use which are the same as for the intravenous heroin user: (1) serum hepatitis is very common; (2) injection of live bacteria can produce bacterial endocarditis, pneumonia, tetanus and infected abscesses; (3) syphilis and malaria can be transmitted by shared needle use; (4) sterile abscesses are caused by barbiturates injected into the tissues surrounding a vein, sometimes producing tissue necrosis; (5) allergic reactions to adulterants may occur.

Intravenous barbiturate users are known as "barb freaks" within the drug using subculture, and occupy a low status within that culture. They may become so engrossed in their drug use that they neglect basic hygiene and nutrition. These patterns of personal neglect are intensified by the lassitude produced by the pharmacological effects of the drug. ◄

In subsequent studies by the Dangerous Drugs Commission, referral patterns for barbiturate detoxification are to be identified. Additional material on medical management will be developed.

For those wishing a telephone message on clinical management of a barbiturate crisis, the Roche "Warm Line" is available (312) 297-4280.

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Drug Administration Grounds For Malpractice

- prescribing the wrong drug;
- failure to note and keep a complete record of a patient's drug sensitivities;
- handwriting so illegible that it results in misreading of a prescription;
- failure to diagnose and treat promptly adverse reactions to drugs;
- failure to warn a patient of possible side effects of certain drugs when used in combination with other drugs or with alcohol;
- injuring nerves in the course of administering drugs.

(Joseph G. Fink: "The Basis in Law," *Drug Therapy* [Oct.] 1974, pgs. 68-71.)

Caution Urged When Prescribing Drugs

The American Medical Association has urged physicians to exercise great caution in prescribing sleeping pills and tranquilizers that might lead to drug misuse or addiction.

"Because of the proliferation of psychoactive substances, the physician, today more than ever before, should guard against contributing to drug abuse through injudicious prescription practices or by acquiescence to the demand of some patients for instant chemical answers to their problems," the AMA declared.

The physician should first determine that there are sound medical indications for using a psychoactive drug, such as a sleeping pill or a tranquilizer. He should then weigh three additional factors: (1) the severity of symptoms in terms of the patient's ability to accommodate them, (2) the patient's reliability as a drug taker, noted through observation and careful history taking, and (3) the dependence liability of the drug itself.

Ten "points to remember" have been suggested when administering or prescribing such products:

1. Use barbiturates and other sedative-hypnotics for relief of severe symptoms, but avoid them for minor complaints of distress or discomfort.
2. Attempt to diagnose and treat underlying disorders before relying on drugs for symptomatic relief.
3. Assess susceptibility of the patient to drug abuse before prescribing barbiturates or any other psychoactive drugs.
4. Use dosages that will not lower sensory perception, responsiveness to the environment, or alertness below safe levels.
5. Know how to administer barbiturates when clinically indicated for withdrawal in cases of drug dependence of the barbiturate type.
6. Using periodic checkups and family consultations, monitor possible development of dependence in patients who are on an extended sedative-hypnotic regimen.
7. Prescribe no greater quantity of a drug than is needed until the next checkup.
8. Warn patients to avoid possible adverse effects because of interaction with other drugs, including alcohol.
9. Counsel patients as to the proper use of medication—follow directions on the label, dispose of old medicine no longer needed, keep medicine out of reach of children, do not "share" prescription drugs with others.
10. Convey to patients through attitude and manner that drugs, no matter how helpful, are only one part of an overall plan of treatment and management.

Medical Management of Alcoholism

Thursday, April 3, 1975, 9:00 a.m. **McCormick Place, Chicago**

Treatment of Acute Alcoholism
Charles Becker, M.D., General Hospital, San Francisco, Calif.

Alcoholic Liver Disease
Charles Lieber, M.D., New York City University of New York
Mt. Sinai School of Medicine

Rehabilitation of the Alcoholic Patient
Max Deisman, M.D., Maryland
Division of Alcoholism Control, Maryland DMH

Sponsored by the Illinois State Medical Society
Committee on Alcoholism and Drug Dependence
Attendance limited to physicians.

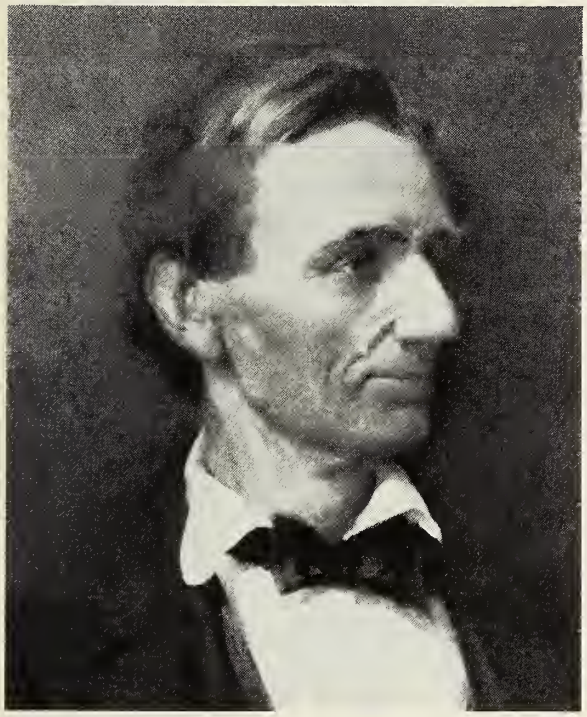
Supported in part by a grant from the Alcoholism Program, Illinois Department of Mental Health and Developmental Disabilities.

Abraham Lincoln—Health, Habits and Doctors

By Emmet F. Pearson, M.D./Springfield

"I have within the last few days, been making a most discreditable exhibition of myself in the way of hypochondria and thereby got an impression that Dr. Henry is necessary for my existence," wrote Abraham Lincoln to his law partner, Congressman John Stuart, on January 20, 1841.

In this statement, Lincoln reveals his overconcern with personal health and his reliance on a physician. A chronological analysis of Lincoln's career and intimate thoughts, as recorded by friends and historians, painfully points out his brushes with death and periods of morbidity and melancholia. Lincoln's health, habits and doctors greatly influenced his career. By looking into some of the intimate aspects of Lincoln's life, the human side of the man comes through in contrast to the idealistic picture portrayed by many historians.



Abraham Lincoln as a young man

The richest source of manuscript material concerning Lincoln's early life is to be found in the Lamon papers, which were perused in the Huntington Library at San Marino (Pasadena) California. William A. Herndon, Lincoln's long time law partner and biographer, collected this vast documentary material and generously made it available to other historians in addition to using it in the LIFE OF LINCOLN by Herndon and Jesse W. Weik. He later sold the material to William Lamon, a one-time law partner of Lincoln, who also wrote on the life of Lincoln. The Huntington Library obtained the collection from the Lamon heirs.

Herndon has been criticized as an unreliable historian, but as a reporter and biographer he had the devotion of a Boswell, and certainly knew Lincoln longer and better than any other historian. He began gathering and recording material before Lincoln's death, whereas other biographers started more than twenty years later. When Herndon's LIFE OF LINCOLN was published, in the 1880's, a loud cry of indignation was raised and Herndon was called a liar, a fool and an embittered destitute drunkard. Herndon forthrightly answered all of these charges and chastised others for suppressing the truth. One edition of a book containing Herndon's material was vigorously suppressed and abridged; some of the material quoted herein may have been a part of the expurgated copy. Not surprisingly, most Lincoln writers use Herndon's material freely when they like what he said, but ignore or condemn that part of his testimony which they do not like.

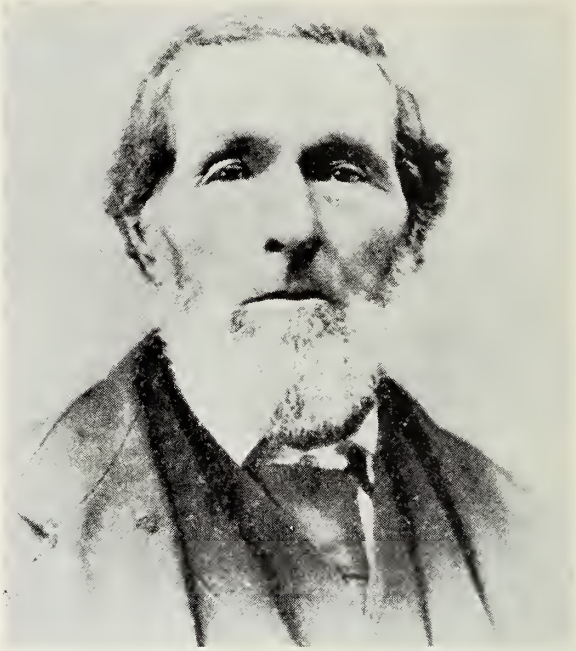
EMMET F. PEARSON, M.D., is Clinical Professor of Internal Medicine and History of Medicine, SIU School of Medicine. A graduate of Washington Univ. School of Medicine, St. Louis, Dr. Pearson has devoted substantial time in exploring medical history, serving as vice-president of the Illinois Historical Society. He is the author of numerous papers on medical history subjects.

A Description of Lincoln

Herndon described Abe as follows: "Mr. Lincoln was of low (bad) physical organization, slow digestion, slow circulation, slow function-blood—not hot—not impulsive—cold flush. Liver had no action, bowels slow, costive, sometimes feverish, sometimes cold, had not a strong life, but a treacherous one. He had no haste, no impulses, no wear of cellular tissue, muscles or nerves. He took life easy, had no haste—no spontaneous emotions, was sympathetic and emotional in the presence of the object."

Lincoln was a muscular youth; however, he was neither a robust, vigorous, nor healthy man. Rawboned and wirey, he stood 6′ 4″ and weighed about 175 pounds. He had stooped shoulders, bony arms and legs, and spidery fingers. His ears were large and set at a right angle to his long head. He had no spring to his gait and walked flat on his feet. He had a dark complexion and often a drawn and worried look, except when he was in animated conversation, at which time his eyes twinkled and he broke into unrestrained laughter. Lincoln's eyes were small, and the left eye turned upward and outward as may be seen in some photographs. At times he had double vision. That he preferred to read lying down was probably because of eye strain, which may have accounted for his chronic fatigue. At age 48 he began wearing glasses for magnification. He may have been color blind because he could not see much beauty in flowers or in the sunset.

Herndon wrote that he thought Lincoln was illegitimate, and that Abe, himself, considered that possibility. Herndon had been told that Thomas Lincoln had testicular atrophy, probably from mumps, and that Abraham Enloe, a neighbor, stated on occasions that he was Abe's father. Some thought that Lincoln's personal appearance and disposition resembled Abraham Enloe rather than Thomas Lincoln. Herndon further stated that he heard in Kentucky that Thomas Lincoln and Abraham Enloe had a terrible fight over Nancy, and that the Lincolns moved to Indiana so that Nancy could not continue her relationship with Enloe. Few historians disagree that Nancy Hanks, Lincoln's mother, was illegitimate. Even by "backwoods standards," the Hanks and the Linkhorns (as they were known in those parts) were at the bottom of the social structure. Abe's mother died of "milksick" in 1819 (a disease caused by cows milk containing a toxic alkaloid from eating snakeroot). Her death, and that of an older sister, Sarah, were the first of many early contacts with premature death in Lincoln's immediate family and among friends, causing him recurrent episodes of despair.



William Herndon
Lincoln's law partner and biographer
Courtesy of Illinois Historical Society

Early Life

Lincoln was fortunate to have been born in a log cabin in the backwoods, and to have grown up in the wilderness, where he learned things not taught in books or schools; he acquired a kind of transcendentalism. This resource of intuition helped him through many episodes of despair and gave him a form of intellectual arrogance.

When he wandered into New Salem, Illinois, in 1831, Lincoln was physically strong but emotionally weak. He became interested in the innkeeper's daughter, Ann Rutledge, who died during the time he was living in the Rutledge Tavern. Although she was engaged to another man, Lincoln took her death very seriously. He was having chills and fever, probably malaria, at that time, and the physical and emotional strain caused a severe nervous breakdown. His physician and confidant, John Allen, of New Salem, evidently performed some very good psychotherapy. He probably encouraged Lincoln to split rails, and to walk through the woods and re-establish his rapport with nature so as to find tranquility. Dr. Allen also probably treated Abe's chills with Chandler pills (quinine), which was a new drug to Illinois at that time.

His Associations

Lincoln had close association with doctors throughout his life, some as friends and others for benefit of his health. Doctors often were community leaders and the best educated citizens. While a storekeeper and postmaster in New Salem, Lincoln read voraciously, borrowing many books from others. From reading he learned to survey, and offered this skill to Dr. Charles Chandler, founder of Chandlerville, not far from New Salem. In exchange, Chandler supplied Lincoln with books, and encouraged him to go into politics.

Some biographers have said that Lincoln was shy with women and indifferent to sex, but Herndon paints a more vivid picture. He recounts that when Lincoln became a state legislator and moved to Springfield, he lived with Joshua Speed, a storekeeper. One day Lincoln said to Speed, "Do you know where I could get some?" Speed, who kept a woman nearby, sent Abe over with a note of introduction. They got into bed and Lincoln asked, "How much will this cost?" When she replied, "Five dollars," he told her he only had three dollars and that he would not do business on credit. He then got out of bed and departed. The woman told Speed later that she had never seen such an honest man, thus the nickname, "Honest Abe."

About 1841, according to Herndon, Lincoln made a business trip to Beardstown, and while there was possibly exposed to venereal disease. Herndon thought that Lincoln's obsession with having contacted syphilis was the reason he broke his engagement to the newly arrived Springfield belle, Mary Todd, in 1841.

Also about that time, Lincoln met the famous Dr. Daniel Drake, of Cincinnati, who was visiting Springfield while making an epidemiological study of disease in the Mississippi Valley. Lincoln later wrote Drake requesting a prescription for venereal disease. Herndon says that Lincoln showed the letter to his friend, Speed, but put his hand over the part that concerned the possibility of syphilis. Drake advised Lincoln to travel to Cincinnati for an examination, but Lincoln did not go. Lincoln's fear of V.D. was probably more psychosomatic than infectious.

Herndon mentions another historical sexy footnote, told to him by Lincoln himself, in the presence of others. One night Lincoln slept in the one room log cabin of a friend near Bloomington. The family's daughter slept in a bed next to him. During the night, Lincoln thought she was getting friendly and he put his hand where it should not have been. The daughter immediately got up and told her mother, but the two decided not to tell the girl's father, because he would shoot Lincoln. The next morning the father did, indeed, get up and get out a big knife. Fortunately he went off to hunt, rather than to use it for the purpose which Lincoln feared.

After the engagement to Mary Todd was broken, Lincoln "lost his mind," spoke of suicide, and was advised by his friend, Dr. Anson Henry, and others, to take a long rest and to visit Joshua Speed's family in Kentucky, which proved to be good therapy. He returned to Springfield to take up a successful law practice and politics. Upon his return, Abe was encouraged by Dr. Elias Merriman to reconcile his differences with Mary Todd—he did and soon married her.

Lifestyle

Lincoln's habits and lifestyle while in Springfield are well documented and give some insights into his health. Although he admitted to be tipsy on one occasion, he seldom drank and never used tobacco. At one time he even joined the forces of the Washington Temperance Society, and drove around the country in a buggy making temperance speeches and giving pledges of temperance to young men. He was not a gourmet; but simply ate to live. He was quoted as saying, "Men abuse their stomachs with imprudence in drinking and eating and in that way health is impaired and ruined and life is shortened." Although a railsplitter in his youth, he admitted he learned to do physical work but never learned to like it. He exercised little, and spent much of his free time reading. His favorites were the works of poet Robert Burns, Shakespeare, and the *Bible*.

Herndon said that Lincoln was an atheist in his youth, and that while living in New Salem he wrote a book extolling infidelity. Historians agree, however, that as tragedies piled upon Lincoln he turned more to religion, but never joined a church (he seldom mentioned Jesus Christ but related directly to God).

Lincoln was superstitious, as were most backwoods Kentuckians of the time, but he did not believe in quack healers, although they were abundant in his time. Lincoln once did take his son, Robert, to Terre Haute, Indiana, to have a "Mad Stone" applied to a dog bite, but that was then considered to be a reliable preventative of hydrophobia. Lincoln said, "The best way to judge a remedy was the peoples faith in it."

His Health

Lincoln had a habit, in the 1850's, of almost daily visiting the Diller Drug Store, Springfield, a hangout for most of the town's intellectuals, including physicians. Records show that he often bought medicine including: pennyroyal, castor oil, ipecac, Brown's mixture, camphor, glycerine, cathartics, blue mass (Mercury), tonics, (no sedatives) and brandy. In addition to self medication, he probably often treated his own family.

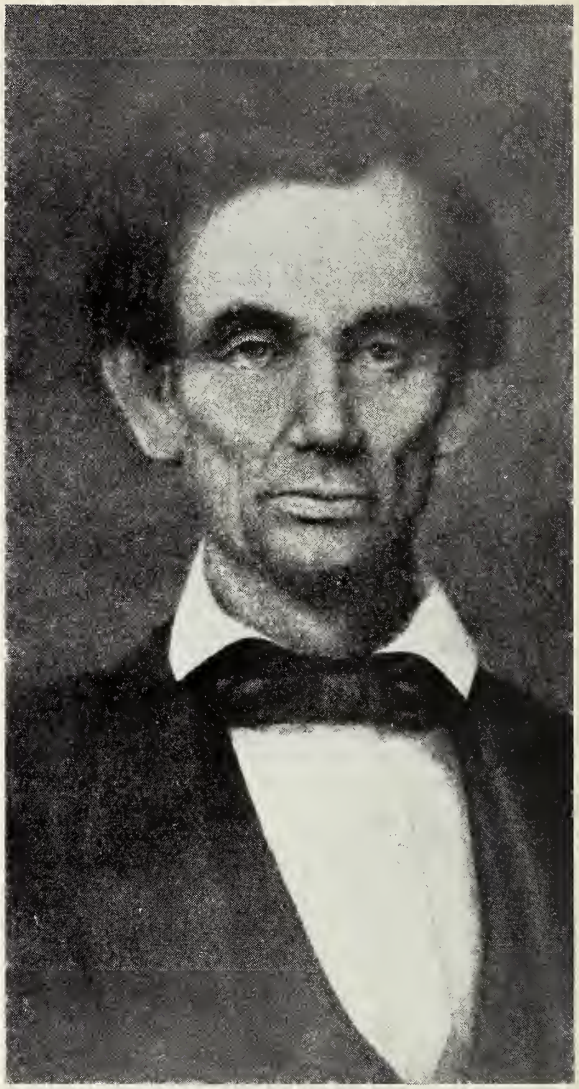
Lincoln described himself as having "hypo," meaning he was a hypochondriac. He never carried a pocketknife for fear he would harm himself. His melancholic, depressive disposition caused him to have several nervous breakdowns. He was a great joke teller, which helped to relieve his melancholia, and he sought company, fun and hilarity to overcome a morbid state of mind.

All of Lincoln's ailments were not psychosomatic. He suffered many minor physical ailments including indigestion, constipation, frequent chills, and ease of fatigue. As a child he had nearly drowned, at 13 he was kicked unconscious by a horse, and at one time he had a tooth extracted which carried with it a piece of jawbone, causing great pain. In July, 1860, the two younger Lincoln sons had severe cases of scarlet fever, and Abe wrote to his old friend, Dr. Henry, that he thought that he "had an inferior type of the same thing."

After serving one uninspiring term in Congress, in 1844 Lincoln returned to Springfield, unemployed. Although offered a partnership with a lawyer in Chicago, he declined, with the explanation that he tended to *consumption* and living in Chicago would kill him. Tad Lincoln, his youngest son, died in Chicago at age 17, from an illness which was certainly T.B.; the death certificate of Eddie Lincoln, who died at age 18 months, stated "consumption." These facts cause one to consider the possibility that T.B. did "run in the family." Lincoln was said to often be feverish and greatly fatigued. No doctor ever diagnosed consumption, but photographs of him near the end of life show that he was cachectic and that he had Hippocratic facies.

Physicians

The same Dr. Merriman who encouraged his marriage, was also to be second at a saber duel between Lincoln and United States Senator James Shields. Merriman may have saved Lincoln's life by helping to stop the duel. He was also known to have surgically removed a "lump" from Lincoln's cheek.



Abraham Lincoln about 1860
Courtesy of Illinois Historical Society

The doctor who was the most intimate with the Lincolns in Springfield was Dr. Anson Henry, who had been a student of Dr. Daniel Drake in Cincinnati. Mrs. Lincoln wrote on several occasions that he (Dr. Henry) was their dearest friend. Dr. Henry may have delivered the Lincoln sons, but no documentation of that exists. He visited the Lincolns in the White House, and was sent by Lincoln to the Puget Sound area on a government mission, where he drowned in a boat accident.

Dr. John Todd, uncle of Mary Todd Lincoln, also a Springfield physician, probably gave the family medical advice. Dr. William Wallace, who married a sister of Mrs. Lincoln, also was con-

sulted for medical advice by the Lincolns, and when Lincoln went from Springfield to Washington to become President, he was accompanied by Dr. Wallace. After Lincoln became President he appointed several of his old doctor friends from Springfield to high political offices.

Among the other doctors in Springfield in the 1840's was Dr. Charles Henry Ray who tremendously influenced Lincoln's political career. One historian, Jay Monahan, called Ray "The man who elected Lincoln." Dr. Ray served with Lincoln on committees which founded the Republican Party. He later forsook medicine for journalism and became part owner and chief editor of the *Chicago Tribune,* just in time to boost Lincoln on the national political scene. He advised Lincoln during the Lincoln-Douglas debates, encouraged Lincoln's abolitionist views, and played a decisive editorial role in electing Lincoln to the Presidency. Ray became a kingmaker for office seekers in the early phase of the Lincoln administration. Lincoln sent Dr. Ray into the South to trade whiskey for cotton during the Civil War.

Within a year after Lincoln became President his gifted son, Willie, contacted a lung disease and died. Greatly depressed, Lincoln cancelled cabinet meetings and all public appearances for several months during the Civil War. He told of having hallucinations and frequent frightening dreams while in the White House.

Lincoln had fever on the day of the famous Gettysburg speech (which may be the reason for its brevity). When he returned to Washington he developed what was thought to have been a mild form of small pox. Lincoln quipped, "Now I have something I can give to everybody." A young Negro servant, Willie Johnson, who had moved from Springfield to Washington, accompanied Lincoln to Gettysburg. When Willie developed small pox and died, Lincoln blamed himself for giving Willie the disease. There is no record of Lincoln or his sons having been vaccinated against small pox.

When President Lincoln was asked to support the Zionist plan to restore European Jews to their homeland in Palestine, he said, "I myself have a regard for the Jews; my chiropodist is a Jew and he has so many times put me on my feet that I should have no objection to giving his countrymen a 'leg up'." A. Zacharie, a most aggressive chiropodist, arrived in America from England in 1837. In addition to treating Lincoln's corns and bunions, Zacharie became a personal confidant and informer to Lincoln. Zacharie called himself doctor and affixed "M.D." after his name, but there is no evidence that he earned this degree.

Lincoln's association with doctors kept him aware of public health problems. While living in Springfield he added his influence to improving sanitation. He was a member of a committee largely made up of doctors who where attempting to promote proper care of privies, removal of putrifying garbage, and general cleanliness in a successful effort to forestall an epidemic of Cholera in the 1830's.

He was much concerned with medical inadequacies in providing care for troops during the Civil War and encouraged reorganization of the medical department. He indirectly played an important role in establishing the foundation for state supported medical and health education. By signing the Land Grant Act, he promoted the establishment of land grant universities across the country, including the University of Illinois.

Lincoln's Death

Dr. Robert Stone, Professor of Medicine at Georgetown University, was the Lincoln's White House family physician. Stone did not keep good records of his patients, which is unfortunate, for he could have shed valuable light on Lincoln's health, and that of Mary Lincoln and the boys.

Photographs of Lincoln taken at the Civil War's end show him thin and exhausted. Some people have speculated that he was at the point of death due to heart trouble or other physical disease. Horace Greeley, the famous editor of the *New York Herald,* saw Lincoln near the end of the Civil War and said he looked so weary and haggard that he seemed unlikely to live out his term. Lincoln said that at the end of each day he was "flabbished" and that the tired part was "inside and out of reach."

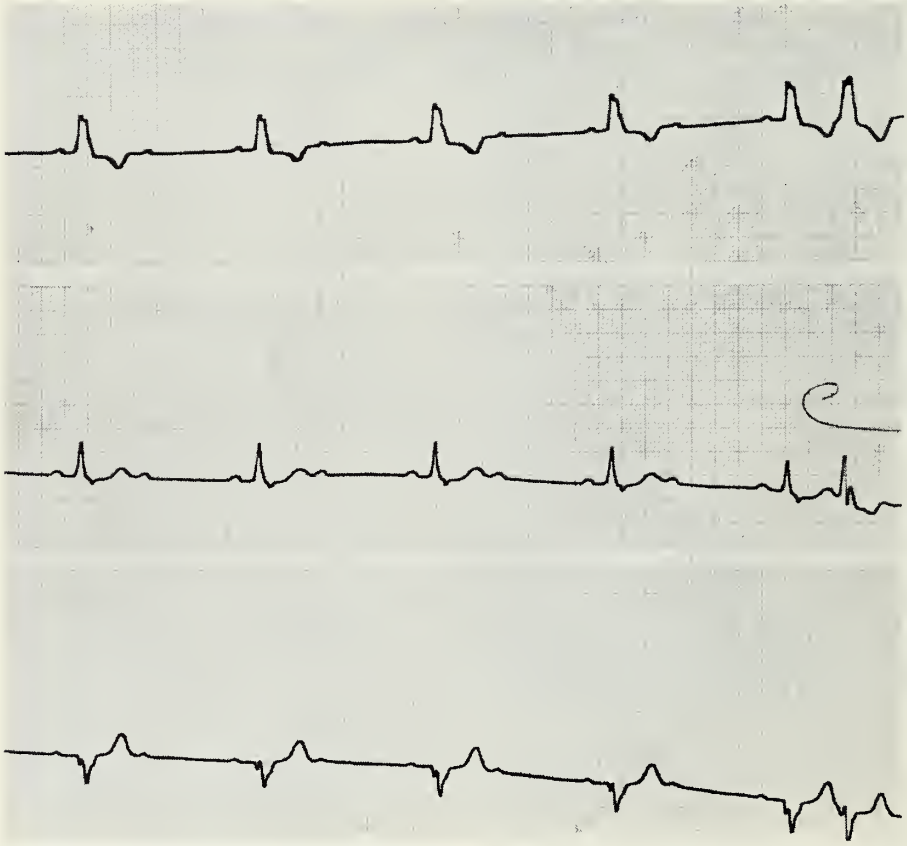
Lieutenant Charles Liele of the Army Medical Department was the first doctor to Lincoln's aid in the Ford Theatre in Washington, after Booth's fatal shot on April 14, 1865. Two other doctors, Charles Taft and Albert King, also appeared promptly and the three doctors moved the stricken President to a house across the street. When Lincoln died a few hours later, nearly every important doctor in Washington, including Dr. Robert Stone and Surgeon General Joseph Barnes, were at his bedside.

Unfortunately, the postmortem examination of Lincoln was limited to the head. A thorough pathologist's examination might have clarified many controversial points about his health. Arm-

(Continued on page 174)

ekg of the month

John R. Tobin, M.D., M.S., Rimgaudas, Nemickas, M.D.,
Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D.,
Sarah Johnson, M.D. and
Rolf M. Gunnar, M.D., M.S./Section of Cardiology,
Loyola University Stritch School of Medicine



A seventy-three year old man came to his physician because he thought his mind was failing. He had been the editor of a company magazine for thirty years and was still working part-time. Some three months earlier he noticed that his mind was not as sharp as it had been and his memory seemed to be poorer. He came for an examination because this situation was persisting. His stamina also was failing. He had been in good health most of his life. A simultaneous lead I, II, and III rhythm strip is shown.

Questions:

1. The ECG shows:
 A. Complete left bundle branch block.
 B. 2:1 Atrioventricular (AV) block.
 C. One premature ventricular beat.
 D. Sinus bradycardia at a rate of 40/minute.
 E. Idioventricular rhythm.

2. Management of this patient should include:
 A. His bundle recording to determine the H-V interval.
 B. Digitalis.
 C. Propranolol.
 D. ECG rhythm monitoring.
 E. A demand pacemaker.

(Answers on page 174)

Thyroid Acropachy

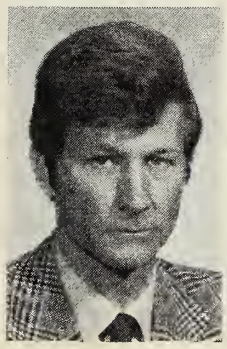
By Joseph G. Ellis, M.D./Urbana

Lopsided, painless swelling, occupying the mid-portion of phalanges and tarsal bones in concert with clubbing of the fingers, presents a curious picture on physical examination. This may be more intriguing to the examiner than bothersome to the patient, whose main complaint is likely to be concern over why his eyes are bulging out. He may otherwise appear not hyperthyroid but, when asked, will give a story of having had hyperthyroidism years ago. That hisory and those physical findings justify a diagnosis of thyroid acropachy. Exophthalmos and painless, bulbous deformities in extremities often including clubbing follow thyrotoxicosis in 1% or less of patients.[1] There is a distinctive X-ray appearance to the bones of the pachydactylous hand or foot.[2-3]

Case Report

A 63-year-old Negro male was admitted to the VA Hospital, Danville, July, 1972, due to pain in his eyes, and bulging of the eyes becoming worse over the previous two years. He also mentioned a painless swelling around the bones of his hands and feet that had become more noticeable over the same period of time. His weight had been stable and there was no history of cough, fever, dyspnea, heart murmur, stroke or headache. In 1969 he had been admitted to a hospital elsewhere because of weakness and weight loss. Records from that hospital describe no unusual eye signs or deformities of hands or feet, but a T_3 uptake was 50.9% (normal 25%-38%). A thyroid scan showed "enlargement" and "the uptake indicates hyperthyroidism." He was treated with radioactive iodine. The patient said he recovered his strength and became asymptomatic over the next year, only to notice the eye and extremity changes during the following two years.

On physical examination in 1972 he had symmetrical exophthalmos (Fig. 1). His thyroid was not palpable. The fingers were clubbed (Fig. 2). There was an asymmetrical, nontender, firm swelling around some of the phalanges and tarsal bones (Figs. 3 and 4). An X-ray of the right hand



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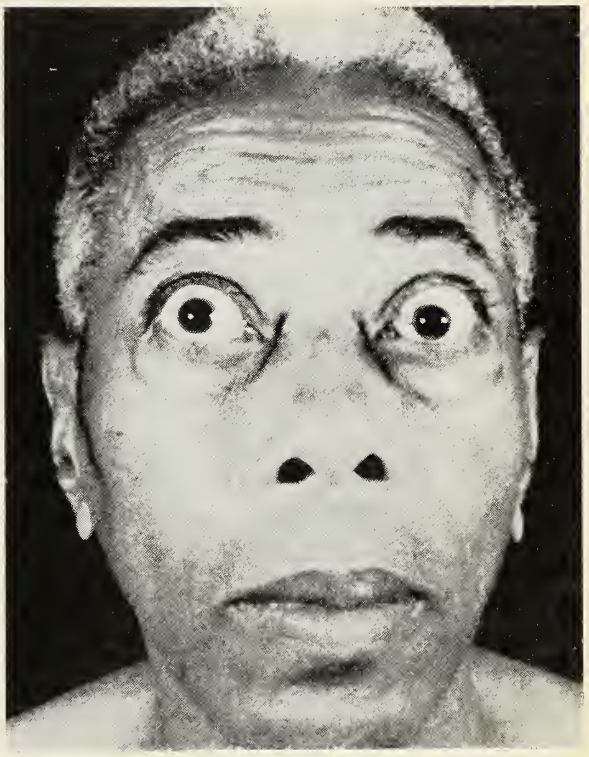


Fig. 1. Appearance of the patient shortly after admission. Proptosis had been slowly progressive over the previous two years.

illustrated slight frothy periosteal proliferation in bone underlying the soft tissue swelling (Fig. 5). Laboratory tests of thyroid function including T_3, T_4, PBI, and I^{131} uptake and scan were all normal. A biopsy of one of the deformed fingers contained "fibro-collangenous tissue compatible with scar."

His main symptom remained progressive eye discomfort. Prednisone, 40 mg. per day, was given for two weeks, followed by reduction to 20 mg. per day for one month. After this a dose of 10 mg. per day was maintained for the next nine months. Eight months after initiation



Fig. 2. Clubbing of the fingers.

of corticosteroids his eye symptoms were much relieved, and both exophthalmos and finger deformity were less (Figs. 6 and 7).



Fig. 3. Firm swelling involving the middle part of some but not all phalanges.

Discussion

No one knows the cause of thyroid acropachy, and no treatment seems necessary.[4] Its unique clinical appearance claims our attention. The distortion of fingers and feet, when accompanied by more familiar clubbing and exophthalmos in a patient with a history of hyperthyroidism, presents a syndrome evoking no other differential diagnosis. The present patient received corticosteroids because of symptomatic exophthalmos. Eye discomfort and proptosis subsided and a cosmetic bonus was recession in signs of acropachy.



Fig. 4. The bones of the feet also had areas of asymmetrical swelling. There is a suggestion of pretibial myxedema.

Kinsella and Back say that a patient with true acropachy always has exophthalmos and always has a history of hyperthyroidism treated by surgery and/or irradiation.[2] Occasionally, there also is pretibial myxedema.[5] The foamy periostial changes on X-ray may suggest luetic periostitis or pachydermoperiostitis, but clinical information would eliminate any doubt about the proper label for these characteristic radiologic changes.

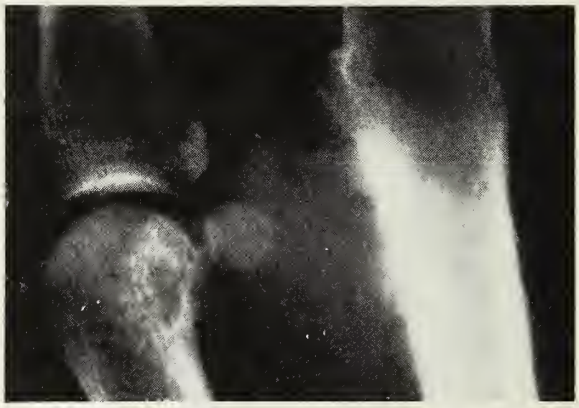


Fig. 5. Foamy proliferation of periosteum over the shaft of a phalanx.

Most authors have speculated about the cause of acropachy—thyroid stimulating hormone, other pituitary factors perhaps. Kriss may be closest to the mark in his discussion of thyroid disease and long acting thyroid stimulator



Fig. 6. Recession of exophthalmos following eight months of corticosteroid treatment.

(LATS).[6] Though not mentioning acropachy specifically, in his analysis of thyroid ophthalmopathy he suggests that the tissue abnormalities characteristic of ophthalmopathy may be the result of the toxic effects of locally deposited antigen-antibody complexes, or may be due to a delayed hypersensitivity reaction involving sensitized lymphocytes.[6] This notion could apply to the changes of thyroid acropachy and would be consistent with the beneficial effect of corticosteroids.

(Continued on page 153)

Maternal Mortality In a Community Hospital

By Howard R. Hone, M.D., and Robert H. MacNerland, M.D./Berwyn

The former chief of obstetrics and gynecology at MacNeal Memorial Hospital, Berwyn, always was emphatic of the fact that "the safest hospital in the world for a woman to be delivered is MacNeal." This stimulated the authors, members of the staff, to investigate maternal mortality at the hospital. The period under consideration began with 1956, when one of the authors became an active member of the staff. It carries through 1970, the year for which the latest complete figures for maternal mortality were available.

During this period, 39,394 women were delivered. A breakdown for that period indicates that family practitioners delivered 20,689 mothers, and specialists 17,487. There were 1,218 deliveries by the house staff.

To show the trend of specialization, in the year 1956 there were 1,853 deliveries by family practitioners and 786 by specialists. In 1970, the statistics revealed 791 deliveries by family practitioners, and 1,231 by specialists. The addition of 303 deliveries by house staff is noted. In 1956 the total house staff deliveries were three.

During the period under study there were three maternal deaths. Of the 39,394 total, this would represent a maternal mortality of 7.6 per 100,000. (The available data for maternal mortality is revealed in tables 1 and 2.) In comparison to the national figures this is felt to be low.[1]

Case Report No. 1

Mrs. C. W., a 27-year-old, gravida II, para II, last menstrual period, June 1, 1962, was admitted July 12, 1962, with a chief complaint of left lower quadrant pain of two weeks duration. Pain was intermittent and gradually became more severe with movement or pressure to the left lower quadrant.

History was noncontributory, except for penicillin allergy. The patient had two normal pregnancies previously. A Frog test the day after admission was negative.

Physical examination revealed tender breasts and a left lower quadrant very tender to palpation. There was mild tenderness in the right lower quadrant and epigastrium. No masses were palpated. Pelvic examination revealed an enlarged uterus and a gynecological consultation noted rebound tenderness in the left lower quadrant. A diagnosis of ectopic pregnancy was entertained and exploratory laparotomy was advised.

Exploratory laparotomy was performed. An intact intrauterine pregnancy was discovered. Further exploration revealed a hepatoma of



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ROBERT H. MacNERLAND, M.D., is from the Department of Obstetrics and Gynecology, MacNeal Memorial Hospitol.

TABLE 1
Maternal Mortality Rates According to Race
Selected Years 1940-1970

Year	Total	White	All Other
1940	376.0	319.8	773.5
1950	83.3	61.1	221.6
1955	47.0	32.8	130.3
1960	37.1	26.0	97.9
1965	31.6	21.0	83.7
1966	29.1	20.2	72.4
1967	28.0	19.5	69.5
1968	24.5	16.6	63.6
1969	27.4[b]	N.A.	N.A.
1970[a]	24.7[b]	N.A.	N.A.

[a]In 1970 the deaths of an estimated 920 women were assigned to complications of pregnancy, childbirth, and the puerperium. The 1970 provisional maternal mortality rate was 24.7 per 100,000 live births. This rate is equivalent of one maternal death for every 4,041 live births.
[b]Preliminary data.
N.A.: Not Available.
Rates per 100,000 live births.

the liver approximately 10 cm. in diameter. The hepatoma was removed by a general surgeon with extensive bleeding, some 4,000 cc of blood estimated as being lost. Bleeding was controlled with gelfoam and the patient received 3,500 cc of whole blood and 3,000 cc of fluids. Shortly after surgery, blood pressure remained at 124/80, pulse 98 regular; urinary output during surgery was 100 cc. Twelve hours following surgery the patient went into shock from further blood loss and expired.

Final diagnosis: 1. Hepatoma 2. Normal early pregnancy.

Case Report No. 2

Mrs. E. R., a 48-year-old, gravida VI, para VI, with last menstrual period in January, 1964, seven weeks prior to admission, was admitted on Feb. 23, 1964, with chief complaints of abdominal pain and nausea for 48 hours. Pain had localized in the right lower quadrant with accompanying emesis and diarrhea.

History revealed a denial of medical illnesses, no allergies, and the fact the patient was a widow for five years. Physical examination revealed a temperature of 98.2°F, blood pressure 100/70, pulse 60. The patient was very dry. There were a few dry ronchi over the lung bases. The abdomen was very tender with guarding, rebound and rigidity. Pelvic examination revealed the uterus deviated to the left and very tender. There was marked tenderness when the left posterior fornix was palpated. Rectal examination revealed no masses, but marked tenderness. The impression was acute, perforated appendicitis. Surgery was deferred until the patient was hydrated. Laboratory reports revealed: WBC progressing from 29,000 to 39,000 with 58% segs and 40% stabs, electrolytes were Na-138, K 4.0, Cl-94, CO_2 14.4 and BUN 80; 2,000 cc of IV fluids were given. After proper hydration the BUN was 58. Exploration revealed diffuse peritonitis with free pus in the peritoneal cavity. The appendix appeared normal, as did the small and large bowel. The ovaries were covered with a fibrinous, purulent exudate. The uterus was the size of a three month pregnancy and boggy. The impression was pyometrium, secondary to endometrial carcinoma. An incision and drainage of the uterus was performed with the removal of blood, clots and placental tissue.

The patient was given erythromycin, IV, and aramine to maintain blood pressure. However, the patient's course was progressively downhill and the patient expired the day of surgery. Final diagnosis: septic abortion with peritonitis.

Case Report No. 3

Mrs. P. B. was a 21-year-old, gravida I, para O, admitted Jan. 4, 1967, with pregnancy at term, in labor. She had a dysfunctional labor and two hours after admission the membranes were ruptured artificially. Two hours later, due to fetal distress, a cesarean section, low cervical type, was performed.

The patient had a history of rheumatic fever and had been taking penicillin prophylactically.

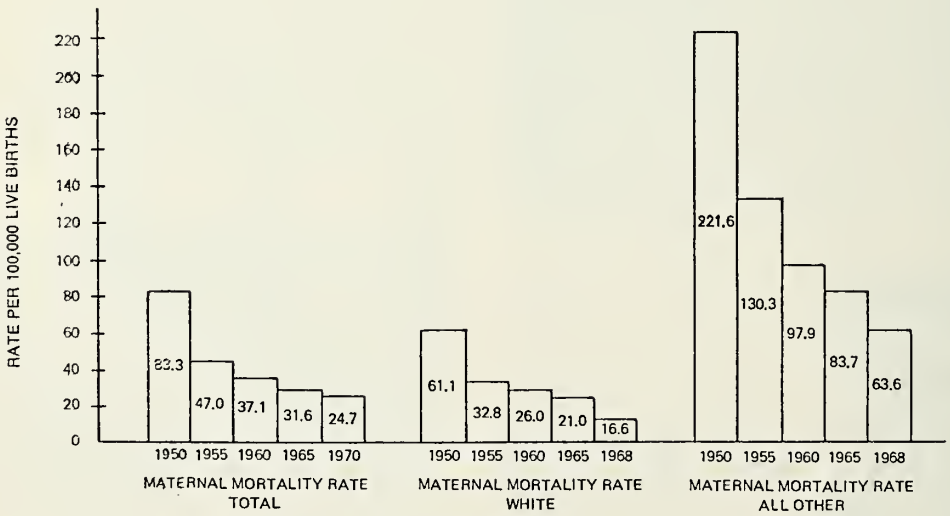


TABLE 2

Maternal Mortality Rates According to Race
Selected Years 1950-1970

On the second post-operative day patient had marked abdominal distension, and a Levine tube was inserted. On the third post-operative day, patient became clammy, shocky and developed jaundice. She was moved to intensive care for monitoring and was given blood, plasma and cortisone. Temperature was 103°F (rectal), blood pressure 0/0, and pulse was 160. Epidermus was cyanotic and blotchy.

Chloromycetin was given intravenously. Cultures from the baby showed E. Coli.

Patient's condition fluctuated with periods of renal shutdown. Severe jaundice ensued and patient was comatose at times. At one time she had a supraventricular tachycardia which could not be converted with direct current countershock. Pronestyl finally converted this. A thrombocytopenia developed. Drugs used during her course were: chloromycetin, ampicillin, mercuhydrin, vitamin K, gamma globulin, cephalothin, digitalis, kanamycin and mannitol.

On Jan. 22, 1967, the patient had a wound dehissence with a small bowel fistula at the lower end of the wound. Her condition steadily deteriorated and she expired on Jan. 26, 1967. Final diagnosis: postpartum sepsis.

Discussion

The review above reports three maternal deaths. It is to be noted that two were the result of an ever present enemy—infection. The other was an extremely rare complication—hepatoma.

The low maternal mortality rate reported here is probably due to several factors. First, the area serviced consists primarily of the middle to upper middle class. Their habits are to seek early medical care. Diets are adequate and patients follow instructions. Second, an excellent, knowledgeable medical staff composed of family practitioners and specialists was present which worked well together. Third, a general good fortune attended all efforts.

Although the decrease in maternal mortality has been remarkable, such mortality still is present. With increasingly better methods of medical treatment many medical conditions are now compatible with successful pregnancies. Diabetes and cardiac conditions may now be carried to successful termination of pregnancy. These conditions, however, add to risk.

The danger of infection is ever present and accounts for the greater number of deaths even at this present time. Infection and sepsis in pregnancy represent high emergencies and should be attacked with the utmost vigor. Their evidence should be attended by massive antibiotic therapy, cultures and supportive therapy.

Although hemorrhage claims fewer victims, it does prepare the way for infection through lowered resistance; care and decision at time of delivery should be exercised to prevent unnecessary blood loss.

Infection, hemorrhage and toxemia still account for 60% of all maternal deaths.[2]

This report covers the period 1956 to 1970 inclusive. Since this period, through May, 1973, an additional 4,501 deliveries have been performed at the hospital without maternal mortality. ◄

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Thyroid Acropachy

(Continued from page 150)



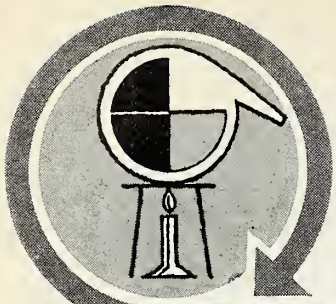
Fig. 7. Appearance of the hands after eight months of corticosteroids. Much of the acropachy has subsided.

Summary

Acropachy means thickening in the extremities. Thyroid acropachy is a rare clinical syndrome linked with hyperthyroidism. A case is persented in which corticosteroids were used. ◄

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new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

HALOG Cream — Local Corticosteroid Rx

Manufacturer:	E. R. Squibb & Sons, Inc.
Nonproprietary Name:	Halcinonide
Indications:	Adjunctive therapy and symptomatic relief of inflammatory manifestations of acute and chronic corticosteroid responsive dermatoses.
Contraindications:	Vaccinia and varicella
Dosage:	Apply to affected area 2 or 3 times daily.
Supplied:	Tubes 15 and 60 Gm, 0.1% cream.

DUPLICATE SINGLE PRODUCTS

ANTITREM — Muscle Relaxant Rx

Manufacturer:	Roerig, Div. Pfizer Pharmac.
Nonproprietary Name:	Trihexyphenidyl HCl
Indications:	Adjunct in all forms of parkinsonism
Precautions:	Patients should be carefully observed for allergic and other reactions.
Dosage:	Increase gradually from 1 to 10 mg. daily depending on patient's response.
Supplied:	Tablets, 2 and 5 mg.

DYSPAS — Antispasmodic Rx

Manufacturer:	Savage Laboratories, Inc.
Nonproprietary Name:	Dicyclomine
Indications:	Adjunctive therapy of peptic ulcer and functional gastrointestinal disorders.
Precautions:	Prescribe with caution to patients with glaucoma.
Dosage:	Adults, 10 to 20 mg. 3 to 4 times daily. Children, 5 to 10 mg. 3 to 4 times daily. Injectable, 20 mg. every 4 to 6 hours.
Supplied:	Tablets, 10 and 20 mg. Liquid, teaspoonful/10 mg. Vials, cc/10 mg. Ampules, 2 cc/20 mg.

ESTROPAN — Conjugated Estrogens Rx

Manufacturer:	Panray Div. Ormont Drug & Chemical Co.
Nonproprietary Name:	Conjugated Estrogens
Indications:	Replacement therapy in estrogen deficiency.
Contraindications and Warnings:	See package insert.
Dosage:	Adjust to lowest level of response.
Supplied:	Coated Tablets, 0.625 mg and 1.25 mg.

IMAVATE — Psychostimulant Rx

Manufacturer:	A. H. Robins Company
Nonproprietary Name:	Imipramine HCl
Indications:	Endogenous and other forms of depression.
Contraindications and Warnings:	Refer to package insert.
Dosage:	Refer to package insert.
Supplied:	Tablets, 10, 25 and 50 mg.

SK-PRAMINE — Psychostimulant Rx

Manufacturer:	Smith Kline & French Laboratories
Nonproprietary Name:	Imipramine HCl
Indications:	Endogenous and other forms of depression.
Contraindications and Warnings:	Refer to package insert.
Dosage:	Refer to package insert.
Supplied:	Tablets, 10, 25 and 50 mg.

SULCOLON — Sulfonamide Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Salicylazosulfapyridine
Indications:	Adjunctive therapy of ulcerative colitis
Contraindications:	Those usual for sulfonamides
Precautions:	Use with caution in patient with severe allergy or bronchial asthma.
Dosage:	4 to 8 Gms daily and adjust to patient's response.
Supplied:	Tablets, 0.5 Gm.

VENTAIRE — Bronchodilator Rx

Manufacturer:	Marion Laboratories, Inc.
Nonproprietary Name:	Protokylol
Indications:	Reversible bronchospasm associated with acute and chronic bronchial asthma, pulmonary emphysema, bronchitis and bronchiectasis.
Contraindications:	Cardiac arrhythmias, insufficiency of the coronary circulation.
Dosage:	2 to 4 mg., four times daily.
Supplied:	Tablets, 2 mg.

Relationship of High Nitrate Community Water Supply To Infant and Fetal Mortality

By Abraham Gelperin, M.D., Dr. P.H., Vijar K. Moses, B.S., and Clyde Bridger, M.S./Chicago

The effect of "excess" nitrates in water supplies upon human infant mortality and fetal deaths, excepting the rare occurrence of methemoglobinemia, is to date unknown.[1-4] A preliminary study in a major Illinois city showed that methemoglobin was present in mothers and their newborn infants during the spring period of high nitrate value (45 p.p.m.) in the city water supply.[5] This prompted an analysis of data on infant mortality, made available by the State Health Department, in selected cities and towns with insignificant nitrate or high nitrate in spring of the year, for the years 1959-1968.[6] Ages in weeks, race, sex and cause of death, as well as live births, in 16 communities were obtained.[7]

TABLE I
Infant Mortality and Fetal Death
Race/Sex: White Females

Year	Nitrate	7 Days	8-28 Days	29-365 Days	Fetal Deaths	Total Live Births And Fetal Deaths
1959	High	4	0	1	2	340
	Hi Spring	25	5	10	31	2,362
	No Nitrates	40	5	13	40	2,954
1960	High	5	1	0	1	338
	Hi Spring	14	0	5	29	2,157
	No Nitrates	34	5	11	41	3,090
1961	High	4	0	0	6	285
	Hi Spring	25	3	5	20	2,197
	No Nitrates	23	3	6	47	2,878
1964	High	3	0	4	5	272
	Hi Spring	13	2	11	22	1,830
	No Nitrates	33	4	11	38	2,660
1965	High	2	0	1	4	255
	Hi Spring	17	1	8	27	1,712
	No Nitrates	38	5	10	34	2,491
1966	High	1	3	1	3	258
	Hi Spring	19	6	10	10	1,637
	No Nitrates	28	4	19	31	2,280
GRAND TOTAL	High	22	3	10	27	1,801
	Hi Spring	169	20	53	142	12,291
	No Nitrates	226	24	90	221	16,888

Rates

Nitrate	7 Days	8-28 Days	29-365 Days	Perinatal 8-365 Days	Fetal
High	22.9	2.3	4.0	6.3	12.0
Hi Spring	21.2	1.4	4.1	5.5	11.7
No Nitrates	26.1	1.6	4.3	5.9	14.1

Rates are per 1,000 Live Births and Fetal Deaths.

Deaths were allocated to month of birth in order to evaluate any possible effect upon infant mortality of ad-lib ingestion of the community water supply during pregancy. Infants in high nitrate areas, not breast fed, usually have been placed on prepared liquid formula during

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TABLE II
Infant Mortality and Fetal Death
Race/Sex: White Males

Year	Nitrate	7 Days	8-28 Days	29-365 Days	Fetal Deaths	Total Live Births And Fetal Deaths
1959	High	7	2	1	6	355
	Hi Spring	32	7	10	27	2,315
	No Nitrates	44	3	26	36	3,064
1960	High	5	0	1	8	361
	Hi Spring	24	5	9	31	2,328
	No Nitrates	34	2	13	48	3,212
1961	High	3	0	2	2	284
	Hi Spring	28	3	12	20	2,109
	No Nitrates	39	2	8	41	2,927
1964	High	4	1	1	6	288
	Hi Spring	29	1	6	21	1,983
	No Nitrates	45	5	17	34	2,609
1965	High	1	0	3	2	268
	Hi Spring	30	4	10	21	1,797
	No Nitrates	28	6	13	30	2,620
1966	High	2	0	2	3	245
	Hi Spring	26	0	6	22	1,759
	No Nitrates	36	6	13	32	2,456
GRAND TOTAL	High	22	3	10	27	1,801
	Hi Spring	169	20	53	142	12,291
	No Nitrates	226	24	90	221	16,888

Rates

Nitrate	7 Days	8-28 Days	29-365 Days	Perinatal 8-365 Days	Fetal
High	27.2	1.7	5.6	7.2	14.9
Hi Spring	25.3	1.6	4.3	5.9	11.5
No Nitrates	26.5	1.4	5.3	6.8	13.1

Rates are per 1,000 Live Births and Fetal Deaths.

the first months of life. Deaths were categorized as per international listings into four groups: circulatory system, monstrosities and other developmental defects, postnatal asphyxia and atalexsis, and all others excepting ICD 750-776. Only the caucasian population was studied because of the low number of non-white population. A preliminary analysis, utilizing comparison of the proportions, revealed consistently similar distributions between sexes among the two nitrate groups, which also showed no significant differences with respect to causes of death. This permitted collapsing data with sex as the major variant.

All information was condensed into three month periods and calculated with a moving monthly average to study the possible noxious effect of season of year, as well as low levels of fetal methemoglobin during April-June on different months of fetal development. Analysis of variance technique showed no effects: differences between sexes were again noted.

Data were obtained on nine communities known to have more than 40 p.p.m. nitrate consistently in the village water supply.[6] Since nitrate ingestion during pregnancy may cause fetal wastage, data on fetal deaths made available were usable for only six years, 1959, '60, '61, '64, '65, and '66.[7] An analysis of perinatal losses (fetal deaths plus infant deaths during first week of life) for these six years was calculated utilizing the covariance analysis technique. (Table I, II, III.) Included in these calculations are data from the nine municipalities with consistently high nitrate value in their deep well water supplies.

As shown in Table IV, the three groups of communities are reasonably comparable as to certain economic and health factors, excepting the small populations in the rural counties containing constant high nitrate village supplies. No city in Illinois was known to have a consistently high nitrate water supply.[6] Available data were for the counties which contained the major cities studied. During the period 1960 to 1970, two had significant increases in population because of markedly enlarged university

TABLE III
White Resident Perinatal Mortality by Sex and
Nitrate Level for each of 6 yrs. in 24 selected communities

Communities		1959	1960	1961	1964	1965	1966	Total	Fetal & Infant Deaths	Live Births & Fetal Deaths
No Nitrates	M	26.1	25.5	27.3	30.3	22.1	27.7	26.5	447	16,888
	F	27.1	24.3	24.3	26.7	28.9	25.9	26.1	427	16,353
	T	26.6	24.9	25.8	28.5	25.4	26.8	26.3	894	33,241
High Spring	M	25.5	23.6	22.8	25.2	28.4	27.3	25.3	311	12,291
	F	23.7	19.9	20.5	19.1	25.7	17.7	21.2	252	11,895
	T	24.6	21.9	21.6	22.3	27.1	22.7	23.3	563	24,186
High	M	36.6	36.0	17.6	34.7	11.2	20.4	27.2	49	1,801
	F	17.6	17.8	35.1	29.4	23.5	15.5	22.9	40	1,748
	T	27.3	27.2	26.4	32.1	17.2	17.8	25.1	89	3,549
Illinois, exclusive of Chicago	M	29.9	30.5	30.0	29.7	28.4	28.7	29.5	12,378	418,866
	F	24.6	24.0	24.2	24.9	24.7	24.4	24.4	9,723	397,732
	T	27.3	27.3	27.1	27.4	26.6	26.6	27.1	22,101	816,598

Mortality Rate = 1000 × (Fetal deaths + deaths during first week) ÷ Fetal deaths + Live births
M = Male, F = Female, T = Total Male + Female.

TABLE IV
Socioeconomics, Physician Availability, and Health Data
for Illinois Communities in Nitrate Study
(1965-1966)

Community	County	State Rank Property Value*	Population In 000s*	Ratio of Phys. to Pop*	Infant Death Rate*	Fetal Death Rate*	Percent of Handicapped School Children*	Nitrate In Water**
Alton	Madison	5	244	1567	19.9	12.9	3.64	Insignificant
Belleville	St. Clair	9	269	1397	23.0	13.5	2.75	
Carbondale	Jackson	49	46	869	24.7	18.2	1.74	
Collinsville	Madison	5	244	1567	19.9	12.9	3.64	
E. St. Louis	St. Clair	9	269	1397	23.0	13.5	2.75	
Marion	Williamson	53	45	1113	24.5	5.2	0.82	
Moline	Rock Island	12	161	1099	20.0	8.4	4.05	
Murphysboro	Jackson	49	46	869	24.7	18.2	1.74	
Rock Island	Rock Island	12	161	1099	20.0	8.4	4.05	
Nitrate high in spring only								
Bloomington	McLean	16	89	905	18.7	14.4	6.24	
Danville	Vermilion	19	96	1074	24.8	20.9	5.47	40
Decatur	Macon	15	124	647	19.8	9.9	5.0	
Streater	LaSalle	13	112	1065	23.2	12.4	3.04	to
Eureka	Woodford	39	25	2038	18.8	14.6	2.17	
Georgetown	Vermilion	19	96	1074	24.8	20.9	5.47	45
Pontiac	Livingston	20	40	1248	17.1	14.0	5.10	p.p.m.
Constantly high nitrate								
Payson	Adams	24	69	884	12.3	11.5	4.03	44 p.p.m.
Chandlerville	Cass	75	14	1255	22.6	9.0	2.78	58 p.p.m.
Arenzville	Cass	75	14	1255	22.6	9.0	2.78	68 p.p.m.
Oquawka	Henderson	85	8	2767	23.3	15.5	0.58	43 p.p.m.
Ashton	Lee	27	41	1411	15.1	26.8	1.60	43 p.p.m.
Hartsburg	Logan	29	34	1210	20.0	10.0	1.10	123 p.p.m.
Mt. Pulaski	Logan	29	34	1210	20.0	10.0	1.10	41 p.p.m.
New Holland	Logan	29	34	1210	20.0	10.0	1.10	66 p.p.m.
Roseville	Warren	48	22	1407	41.2	29.4	1.69	54 p.p.m.

*Data by county
**Data for each community

(Continued on page 186)

Cause of Hypertension

By Hansel M. DeBartolo, Jr., M.D./Danville, Pa.

Conditions resulting in hypertension may be divided into three categories: those raising mainly systolic pressure; those raising mainly diastolic pressure; those raising both systolic and diastolic pressure. Systolic pressure may be increased in hyperthyroidism, anemia, AV fistula, Pagets disease of bone, beri beri and malnutrition. Diastolic pressure may be increased in essential hypertension. Systolic and diastolic pressure may be increased in essential hypertension and certain endocrine fenal, cardiovascular, musculoskeletal and neurologic conditions; and in toxemia of pregnancy.

Physiological Factors

In persons with a certain genetic susceptibility, ingestion of salt leads to a cyclic chain of events by which salt is retained. (Table 2) Salt intake is followed by an obligatory increase in plasma volume which results in increased peripheral resistance and hypertrophy of the vascular wall. This increase in renal vascular resistance is followed by a decreased renal blood flow, which results in renin secretion and activation of the renin system, leading the Aldosterone secretion and retention of salt. The mechanics of the renin system[1] are outlined in Table 3.

These relationships are necessary to develop an understanding of primary and secondary Aldosteronism. In primary Aldosteronism, the secreted agent Aldosterone causes a negative feedback inhibition upon the renin system resulting in a decreased serum renin. However, in secondary Aldosteronism the underlying condition causes renin secretion and Aldosterone release as result of stimulation of the renin system, and thus the levels of both renin and Aldosterone are increased. (Table 4) In the normal individual both renin and Aldosterone are increased in salt deprivation and potassium administration.



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Pseudoaldosteronism may present due to ingestion of licorice ammonium glycyrrhizate, which is a constituent of certain candies and breath fresheners and sometimes used for peptic ulcer treatment. In pseudoaldosteronism, plasma renin and Aldosterone are both decreased and yet there is excessive reabsorption of sodium in the distal renal tubule.

Bartter's syndrome[2] is a normotensive, hypokalemic form of secondary Aldosteronism in which both renin and Aldosterone levels are increased and yet, due to a fault in vascular response, the blood pressure remains normal.

TABLE 1

Causes of Hypertension

	SYSTOLIC	
Anemia	Malnutrition	Beri Beri
A-V Fistula	Hyperthyroid	Pagets Bone
	SYSTOLIC AND DIASTOLIC	
Endocrine	Hypothalamic	Aldosteronism
	Pituitary	Pheochromocytoma
	Cushing	Neural Crest
Neurologic	Cerebral Accident	Poliomyelitis
	Neoplasm	
Renal	Pyelonephritis	Renal Art. Stenosis
	Glomerulonephritis	Polycystic Kidney
	Diabetic Kidney	Outflow Obstruction
	Hemangiopericytoma	
Cardiovascular	Coarctation Aorta	Atheroma
	Extrinsic Bands	
Other	Toxemia	Polycythemia
	Collagen Disease	Essential
	DIASTOLIC	
	Essential	

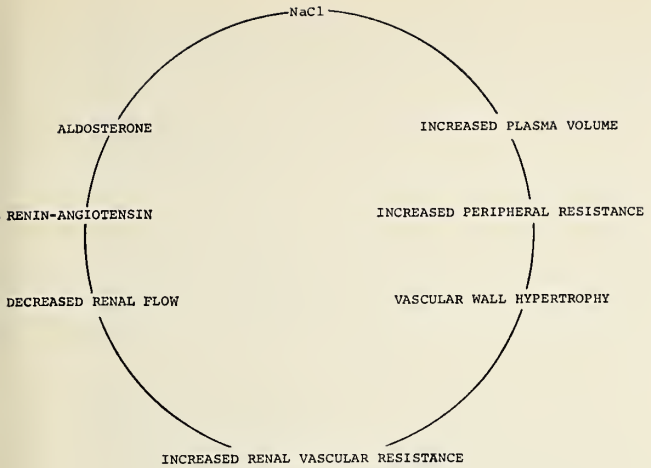


TABLE 2. PHYSIOLOGICAL RELATIONSHIPS

Biochemical Factors

Important to the clinical laboratory study of hypertension is knowledge of the underlying pathways of catecholamine synthesis and metabolism. (Table 5)

Using Table 4 as reference, the laboratory differentiation of Pheochromocytoma from neural crest tumors becomes most evident. (Table 6) Because neural crest tumors secrete Dopamine (or precursors), we observe an increase in all products from Dopamine onward in the pathway, and because Pheochromocytomas secrete norepinephrine and epinephrine, we observe an increase of all products from this later stage of the pathway onward, but no increase of Dopamine or of its metabolite homavanillic acid. While in both disorders we observe an increase in catecholamines and their metabolites.

TABLE 3
The Renin System

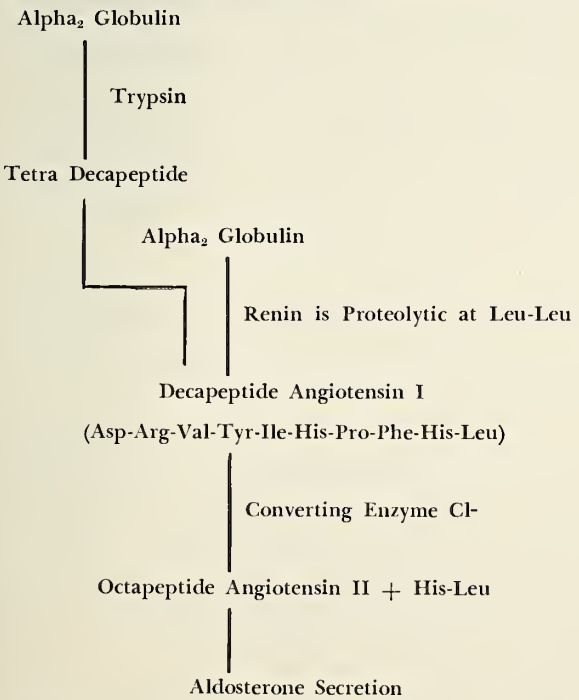


TABLE 4
Differentiation Primary from Secondary Aldosteronism

	Primary	Secondary
Plasma Renin	Decreased	Increased
Plasma Mg	Decreased	Normal
Electrolytes	Decreased K	Depends on
	Decreased Cl	Underlying
	Increased Na	Condition

TABLE 5

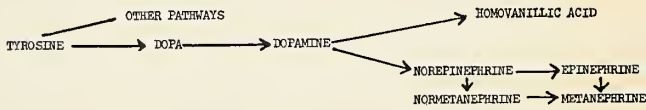


TABLE 6
Differentiation Pheochromocytoma from Neural Crest Tumor

	Pheochromocytoma	Neural Crest
Catechols	Increased	Increased
VMA	Increased	Increased
Metanephrines	Increased	Increased
Dopamine	Normal	Increased
HVA	Normal	Increased

Prostaglandins

The prostaglandins comprise a large family of fatty acids derived in tissues from dihomo-gamalinolenic and arachidonic acid.[4]. These substances have been reported in active reproduction, central and peripheral nervous system transmission, cyclic-AMP metabolism, muscle contraction, calcium metabolism, lipid metabolism, platelet aggregation and other physiological events, including blood pressure regulation.

Three distinct classes of prostaglandins which have an effect upon blood pressure have been isolated from the kidney and identified as prostaglandins E, F[5] and A[6] (PGE, PGF and PGA). The PGE and PGA compounds are peripheral vasodilators and produce a lowering of

blood pressure which is accompanied by an increase in cardiac output secondary to reflex tachycardia, and a drop in peripheral resistance.[4] The PGF compounds are weak arteriole dilators or vasoconstrictors which increase venous return and cardiac output, and raise blood pressure.

Because PGE and PGF appear to be degraded in the lung[7], their roles as circulating factors seem doubtful. However, PGA have been shown to pass thru the lung without severe degradation.[8].

The PGA compounds have also been shown to inhibit angiotensin and epinephrine acid to cause increased kidney excretion of sodium, potassium and water.

Thus growing evidence seems to show that the prostaglandins, especially PGA, may be involved in blood pressure regulation. ◄

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Doctor's News

75 Washington Roundup A Success

The annual ISMS Washington Roundup, January 19-22, saw approximately 100 physicians, wives and staff participate in some very informative discussions in the nation's capitol. The thrust of this year's conference was increased activity in national health issues by local physicians interacting with their Congressmen . . . an expansion of the successful ISMS state legislative **Key Man Program.**

The necessity for grassroots participation by physicians was underscored throughout the three-day program. Congressman Edward Derwinski set the tone at the keynote breakfast by strongly urging Illinois physicians to closely monitor national issues, and then to communicate their opinions directly to their Congressmen. A staff briefing by the AMA Washington office continued the theme as Harry Hinton, Deputy Director of Public Affairs Division, outlined AMA plans to work more closely with local physicians on legislative matters, an area that has drawn some criticism in recent years.

The group also heard from Stan Jones, Senator Edward Kennedy's top assistant on National Health Insurance, who indicated that NHI would be a top priority item of the new Congress, and from Lee Hyde, M.D., one of the principal architects of HR 16204, the recently enacted national health planning bill. Dr. Hyde, in anticipation of hostile comments from the group, made the point that *at no time* in the formative stages of the bill did AMA raise any objections to the provisions that later formed the basis for their unsuccessful appeal to President Ford for a veto.

A great deal of Roundup time was left unscheduled so that physicians could meet privately with their Congressmen. One such meeting involved the officers of ISMS and Congressman Daniel Rostenkowski, Chairman of the Health Sub-Committee of the House Ways and Means Committee. Congressman Rostenkowski indicated that he believes that the NHI bill that eventually emerges from Congress will be a compromise drawn from input from all interested parties. The Sub-Committee will not meet until March, so a final bill probably will not pass out of the House until late in the year, pushing Senate action into 1976.

The Roundup concluded with the annual ISMS Congressional Reception, illustrated with pictures on the following page.

PHYSICIANS IN THE NEWS—Dr. Robert Mendelsohn, Evanston, has recently been appointed to the Illinois Medical Examining Committee. Dr. Mendelsohn is Assistant to the Executive Vice President, Michael Reese Hospital, Chicago. Other recent appointees are Drs. Lester Nathan and Basil Chronis. Dr. Nathan is a practicing pediatrician in Skokie. Dr. Chronis is from Palos Heights, Ill. Other members of the Ill. Medical Examining Committee are Mays Maxwell, M.D.; Luis Yarzagaray, M.D.; Paul Tullio, D.C.; and Dale Richardson, D.O.

Our editor, Dr. T. R. Van Dellen, has been appointed to the Chicago Board of Health by Mayor Daley. The City Council Committee on Health approved Dr. Van Dellen's appointment January 20th.

Mrs. Arthur Goodyear, wife of ISMS Trustee Arthur Goodyear, M.D., 7th District, died Friday, January 24. Memorial services were held at the Brintlinger Funeral Home on Tues., Jan. 28th.

ISMS SUBCOMMITTEE ON REDISTRICTING solicits the comments and recommendations of individual members and county medical societies on the possible redistricting of ISMS. The committee would appreciate hearing from all counties so that their report to the House of Delegates will reflect a broad range of views. An ISMS district map was published in the October, 1974, Reference Issue of the Illinois Medical Journal. Send comments to the subcommittee chairman: Dr. John Ring, c/o ISMS, 360 N. Michigan, Chicago, Ill. 60601.

Personalities at the ISMS Washington Roundup Congressional Reception



Dr. Lorin Whittaker, Peoria, (left) and Congressman Robert Michel.



Mrs. Fredric Lake, Congressman Edward Madigan, Dr. Fredric Lake, Evanston, ISMS President, and Mrs. Madigan.



Congressman George O'Brien, Dr. Albert W. Ray, Jr., Joliet, and Dr. Lake.



Dr. Eli Borkin, Carbondale, Congressman Paul Findley, Congressman Paul Simon, and Dr. Joseph Bordenave, Geneva, Chairman ISMS Board of Trustees.



Dr. Theodore Grevas, Rock Island, and Congressman Tom Railsback.



Congressman Edward J. Derwinski addressing the Roundup attendees.



Dr. Joseph Skom, Chicago, Congressman Abner Mikva, Dr. Fred Tworoger, Skokie, and Mrs. Tworoger.



Dr. G. W. Giebelhausen, Peoria, Dr. Grevas, Congressman Michel, and Congressman Henry Hyde.



Congressman Tim Hall, Dr. David Clark, Aurora, and Mrs. Clark.



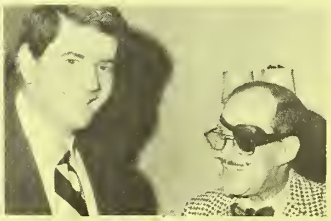
Congressman Madigan, Dr. A. E. Livingston, Bloomington, and Mrs. Madigan.



Dr. Orren Baab, Hinsdale, Sky Baab, Legislative Assistant to Congressman McClory, Mrs. Baab, and Congressman Robert McClory.



Dr. Skom, Dr. Lake, and Congressman Frank Annunzio.



Congressman Madigan and Dr. Bordenave.



Congressman Railsback, Dr. Jerry Ramunis, Victoria, and Dr. Grevas.



President's Page

Unified Membership

There are rumblings that an attack on "unified membership" is brewing in some sections of the state. I hope the following observations will convince you that membership in organized medicine must be defined as membership in the local (county medical society), state (ISMS) *and* national (AMA) organizations.

Each physician needs not only the local and state medical societies, but also the AMA—just as we need not only state and local government, but a federal apparatus as well. Each stratum of organized medicine is essential to the effective pursuit of our goals, just as each tier of government is necessary to the public welfare.

The mounting and monstrous intrusions of government into our professional lives have manifested the need for a unified voice at the state and national levels where "HEALTH" has become a major issue, and your professional freedom and judgment are under direct assault.

ISMS is needed to orchestrate the voices of 92 county medical societies and their thousands of members into a powerful chorus that, in unison, clearly enunciates the theme and maximizes our effect in Springfield. ISMS also is needed to provide the instruments, soloists and the accompanyment not available at the local level. Likewise, the AMA is needed to coordinate and amplify the voices of the 50 states so that our message has maximum impact in Washington.

While I have singled out the necessity of a unified approach to organized medicine's governmental relations, the same rationale applies to all other facets of our objectives and activities—whether they are the improvement of medical education, the promotion of the art and science of medicine or the betterment of the quality of life.

Membership in all levels of organized medicine is an essential component of professional citizenship, and like political citizenship should not be fragmented. Do you want a voice in government only at the city and county levels? Only at the state level? Or only at the national level? I'm sure you would feel disenfranchised if you were deprived of a voice in any of these.

Citizenship—both political and professional—is not, of course, without cost. Your dues—the cost of professional citizenship—are needed at all levels so that organized medicine will remain an effective force. This cost also includes the desperately needed special assessment recently voted by the AMA House of Delegates. I urge prompt payment of your dues and the special AMA assessment so that organized medicine may continue to serve you and the public good uninterrupted by depleted resources.

We must maintain "unified membership" in Illinois, and urge all other states to retain or adopt this requirement.

Fredric D. Lake

Fredric D. Lake, M.D.

IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

Gonorrhea, according to the national Center for Disease Control, is, if the parenteral route is chosen, most effectively treated with aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported.(See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IN SYPHILIS

INJECTION

Bicillin® LONG-ACTING

(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

For deep intramuscular injection only.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: Units benzathine penicillin G (as active ingredient): 2,400,000 units in 4-cc. single dose disposable syringe. Each disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben, and 0.01% propylparaben. 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. povidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101



*U.S. Dept. of Health, Education, and Welfare: VD Fact Sheet 1972. Publication No. (HSM) 73-8195.

Neuropsychological Manifestations of Lead Poisoning

Lead poisoning accounts for an average of 0.2% of all admissions to Children's Memorial Hospital, Chicago. The majority of these patients present with neurological symptoms and signs. In the years 1950-1970, the annual frequency of admissions of children with plumbism in our hospital has varied from two up to forty and the mean annual incidence was 15. (Fig. 1) The marked apparent increase in cases in the years 1961 and 1962 is not explained by a change in overall admissions, this remaining about constant at 7500 per year.

Clinical CNS Syndromes

The neurological manifestations of lead poisoning are protean in nature, and the major syndromes are as follows: (1) acute lead encephalitis; (2) chronic lead encephalitis; (3) cerebellar ataxia; (4) convulsive disorder; (5) behavior disorder; (6) learning and perceptual disorders; (7) mental retardation; (8) peripheral neuropathy.

Acute encephalopathy. Convulsions, delirium, coma, and vomiting are presenting symptoms and signs.[1] Convulsions may be generalized or focal. Acute encephalopathy may develop after an initial period of irritability, anemia and anorexia; it may be precipitated by acute infection or metabolic disturbance, but in some cases there are no premonitory symptoms or signs. Neurologic examination reveals papilledema, fixed dilated pupils, hyperreflexia or depressed deep tendon jerks, Babinski signs, and often, nuchal rigidity. Skull X-ray shows spreading of the sutures, and the cerebrospinal fluid is under increased pressure with pleocytosis and elevated protein. This syndrome is most frequent in young infants during the summer months. If the acute encephalopathy is corrected, complete recovery is unusual and sequelae include hemiparesis, ataxia, mental retardation, convulsions, and optic atrophy.

Chronic encephalopathy. After repeated nonfatal episodes of acute encephalopathy a chronic syndrome emerges resembling a progressive degenerative cerebral disorder,[2] manifested by convulsions, ataxia, and mental deterioration.

Cerebellar ataxia. This may occur as the initial and main manifestation of central nervous system involvement, but more frequently as a complication of acute or chronic encephalopathy.

Convulsive disorder. Convulsions may be generalized or focal in pattern. They may occur spontaneously or in association with fever and intercurrent infections. They may be misdiagnosed as simple febrile seizures if they are short in duration and unaccompanied by changes in the cerebrospinal fluid.

Behavior disorders. These consist of irritability, frequent crying, inattention, impulsiveness, temper tantrums, and hyperactivity. Anemia, anorexia and loss of weight are frequently concomitant, but not invariable.

Learning disorders. Perceptual deficits include visual-motor incoordination and auditory imperception, and the child with the learning disorder complicated by subtle neurologic abnormalities such as incoordination may be classified as having minimal brain dysfunction. Despite average intelligence, the child fails to achieve in school up to the level of his potential. Improvements in behavior and learning have been reported after chelation therapy (Sachs et al.).[3]

Mental retardation. Delays in development and regressions in intellect and behavior occur as neurologic sequelae of acute and chronic lead encephalopathy and have been reported in the absence of overt signs and symptoms of lead intoxication.



J. GORDON MILLICHAP, M.D., is Professor of Neurology and Pediatrics, Northwestern University Medical School, and Attending Neurologist, Children's Memorial Hospital and Passavant Memorial Hospital, Chicago.

In one study by Perlstein and Attala,[4] among 58 children treated for asymptomatic lead poisoning five, or 9% were observed at follow-up examination to be mentally retarded. Admittedly, this study was retrospective, and one cannot be certain that mental retardation did not antedate lead poisoning. Pica, a common prelude to plumbism,[1] may be a manifestation of emotional disorder or mental retardation, and the milder symptoms of lead poisoning are nonspecific and their significance often difficult to interpret.

Polyneuropathy. Wrist drop due to radial nerve involvement, a common manifestation of lead poisoning in adults, is uncommon in children. When neuropathy occurs during childhood, it usually affects the peroneal nerves and results in foot drop.[1] Motor nerves and muscles subjected to the greatest use and fatigue are those chiefly affected. Diaphragmatic paralysis is a rare complication.

Differential Diagnosis

Acute lead encephalopathy must be distinguished from other forms of toxic encephalopathy, including arsenic, thallium and Reye's syndrome. Meningitis, particularly tuberculous meningitis, brain tumor and brain abscess should be excluded. Lead poisoning may occur at blood lead levels below 60 and even 50 mg per 100 ml, but some children with blood lead levels well beyond 100 mg per 100 ml appear well and asymptomatic. The finding of an elevated blood lead level alone should not be accepted as pathognomonic evidence of lead in the etiology of convulsions and coma.

Treatment of Encephalopathy

Convulsions should be controlled with phenobarbital and the cerebral edema treated with steroids and mannitol. Urine flow is established by appropriate fluid therapy, and body temperature is reduced to normal levels. Residual lead is removed from the bowel by enema and treatment with 2, 3-dimercaptopropanol (BAL) and EDTA by intramuscular injection is initiated and continued for 5 to 7 days.

The use of surgical decompression is controvesial and is usually reserved for patients in whom increased intracranial pressure persists beyond the initial 5-day treatment period and in chonic encephalopathy.

Prognosis of Encephalopathy

A mortality of 20% is to be expected and survivors sustain a variable amount of permanent nervous system injury. In one study of 425 children with lead poisoning,[4] 39% had some evidence of neurologic sequelae and among 59 children with lead encephalopathy, 82% were left with handicaps.

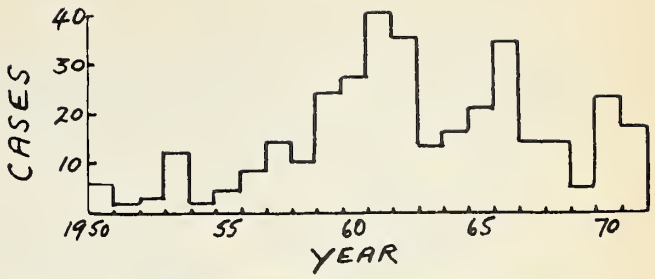


Figure 1. Annual admission of patients with lead poisoning at Children's Memorial Hospital, 1950-1970.

Further efforts must be devoted to the prevention of lead poisoning, but the recognition of early symptoms and signs of intoxication and prompt therapy should reduce appreciably the number of fatalities and permanent neurologic sequelae. ◄

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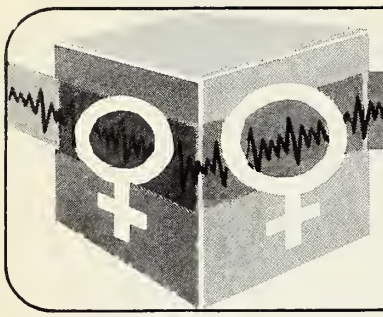
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pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

State Convention 1975

The 1975 State Convention/Annual meeting will be held April 2-4, at the McCormick Inn in Chicago. The by—law revisions will be presented for voting and it is important that member-delegates attend.

Theme of the Convention: "Happiness is - - - - -"

Following is the order of business which has been prepared by Mrs. Harold Zenisek and her committee.

Tuesday, April 1—4:30 p.m.—Pre-convention Board meeting and dinner.

Wednesday, April 2—8:30 a.m.—Members-at-large, Caucus coffee
9-9:30 —By-Laws, "Buzzin"
9:30 —1st Delegate Session
a. Keynote speaker—Mrs. Howard Liljestrand.
b. Report of the nominating committee
c. Election of Officers
d. Presentation of Amendments to the by-laws
e. Presentation of Awards for membership, AMA-ERF, and Health Careers.
12:30 —Presidents luncheon—Fashion show by Saks Fifth Ave.
3:00 —2nd Delegates Session
Evening —Reception for the State President—Mrs. Thomas Glatter.

Thursday, April 3—9:30 a.m.—County Day
12:30 p.m.—Installation luncheon
Wau-Mu performers from Northwestern University
3:00 Leadership workshop

Friday, April 4—7:30 a.m.—Public Affairs Breakfast—Michael Howlett—speaker
9:30 —3rd Delegates Session
a. Adoption of the Budget
b. Election of the Nominating Committee
c. Elections of the Delegates to the National Convention
11:00 —Post Convention Board Meeting



Take your C.M.E. by the sea

49 Continuing Medical Education courses at AMA's Annual Convention, June 14-18, 1975 Atlantic City, New Jersey

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Also featured are a number of special interest programs: a two-day session on the Medical Aspects of Sports, a series of special courses on clinical pathology, and a joint program by the American Veterinary Medical Association and the AMA on diseases transmitted to man by household pets. Physicians' wives and families will be offered interesting programs co-sponsored by the AMA's Council on Scientific Assembly and the Woman's Auxiliary of the AMA.

For more information, write:
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Atlantic City

Lincoln—Health, Habits, Doctors

(Continued from page 147)

chair post-postmortem diagnoses have been: endocrine disorders, hypogonadism, tuberculosis, Marfan's Syndrome, old depressed skull fracture with neurological complications, heart failure and oedipus complex with other psychiatric abnormalities.

In conclusion, by contemporary standards Lincoln would not have appeared fit emotionally, and possible not physically, for the rigors of the Presidential race and the responsibilities of that high office. ◄

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EKG of the Month

(Continued from page 148)

Answers: 1. A,B,C 2. A,D,E

The three lead rhythm strip shows a sinus rhythm, complete left bundle branch block, 2:1 AV block, and one premature ventricular beat (last beat in strip). This patient's complaints involved a reduction in cerebral blood flow that seemed to affect his higher thought processes. Syncope and heart failure were not problems. Both digitalis and propranolol could increase his AV block and were not indicated. He was hospitalized and his ECG rhythm was monitored. The rhythm remained stable at 2:1 AV block as seen in the ECG. A 2:1 block cannot properly be labeled either type I (Wenckebach) or type II (Mobitz) because one needs to know how a second consecutive sinus beat will be conducted. If available, a His bundle recording could establish the level of the AV block, i.e. in the AV node with a prolonged A-H interval or in the His-Purkinje system and the right bundle branch with a prolonged H-V interval. This could be important from a prognostic viewpoint in the absence of any cardiac medications. A demand pacemaker was placed permanently via the transvenous approach. After the pacemaker was placed the patient felt his mind had become sharper again.

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References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

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Comparative Study of the Effects of Different Fluorescent Lights in Phototherapy

By Shig Yasunaga, M.D., Arnold J. Rudolph, M.D., and Luis Felemovicius, M.D./Urbana

Phototherapy is used therapeutically in nurseries for neonatal hyperbilirubinemia. Centers around the country are reporting the occurrence of kernicterus in low birth weight infants at concentrations which were previously considered within safe limits;[1,2] hence, there is urgent need for rapid lowering of serum bilirubin. Considerable controversy exists over the use of narrow band blue light as a treatment of choice for hyperbilirubinemic infants versus the full spectrum "white light" sources.[3,4] Illuminating engineers point to the broad spectrum bulb as more closely resembling the natural light in the physiologic spectrum since blue lights have minimal representation in the normal visible spectrum.

Footcandles and lumens are visible units of measurement of light intensity. These terms, though, are not the proper units of measurement for the bilirubin-degradative properties of the bulb, because the spectral energy characteristics of the lamp are not taken into consideration. On the basis of lumens alone, one would select the green 40-watt fluorescent over the 40-watt cool white fluorescent, as the green light would produce 4500 lumens compared to 3140 lumens for the cool white light.[5]

Bilirubin is most rapidly and effectively altered by irradiation in the violet blue portion of the visible spectrum, at approximately 420 to 460 nanometers. Sisson noted that the greater energy source in that wavelength, the more rapid the decomposition of bilirubin, both *in vivo* and *in vitro*.[6,7]

Energy distribution curves of various lamps used in phototherapy and their relative energies are compared in Figure 1. Due to variances in energy output of the light under consideration, the spectral energy distribution curve can show only the relative energy emission at the particular wavelength. The marked differences in the energy emitted by each light throughout the visible spectrum can be easily noted. The blue lamp has the highest relative energy in the 420 to 460 nanometer range. The broad spectrum bulbs, CritiColor, Vita-Lite and Chroma 55 have a curve approaching 5500° Kelvin, thus resembling the natural outdoors. Examination of their spectral energy distribution curves shows less relative energy in the 420 to 460 nanometer range when compared to the blue, but continuing at a high level throughout the visible spectrum in contrast to the sharp dropoff occurring with blue fluorescent lighting. The relative energy of the cool white bulb is low in the 400 to 450 nanometer range, then rises to a peak in the yellow spectrum at 550 to 600 nanometers.

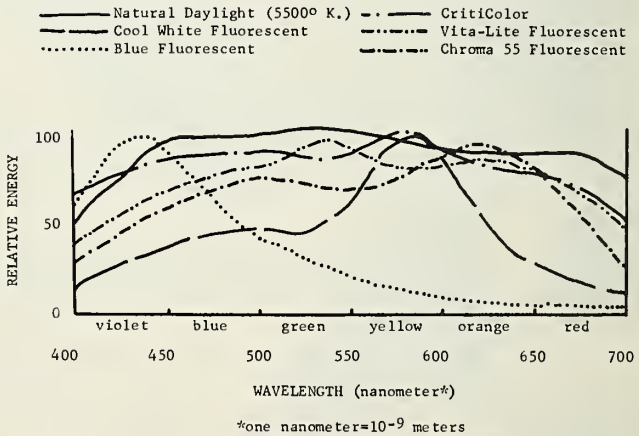


Fig. 1. Spectral energy distribution curves (all curves approximate) Mercury lines omitted



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ARNOLD J. RUDOLPH, M.D., at the time af this poper was Professar af Pediatrics, Baylor College af Medicine. LUIS FELEMOVICIUS, M.D. was a Research Fellow in Pediatrics at Baylor College af Medicine.

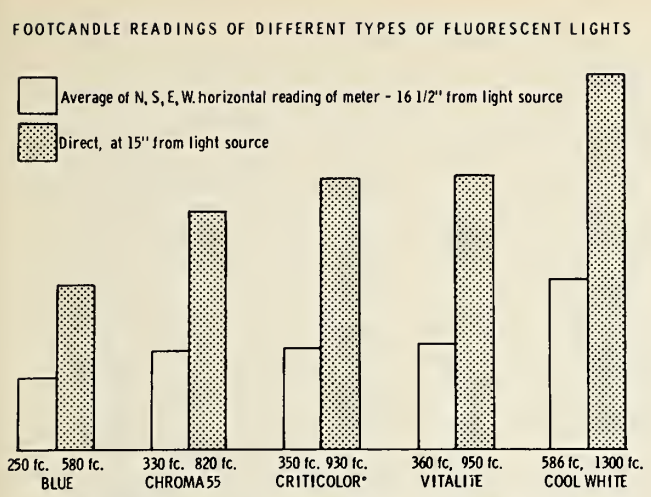


Fig. 2. Footcandle readings of the different fluorescent lights.

The conclusion is thus made that, in the treatment of neonatal hyperbilirubinemia, the particular type of fluorescent light used, because of varied spectra, becomes an important factor in the efficacy of therapy. Accordingly, an *in vivo* study was designed to evaluate the efficacy and merits of various fluorescent bulbs available on the market.

Materials and Methods

This study was carried out at Jefferson Davis Hospital in Houston, Texas. Infants observed were selected from the 1,465 neonates born between January 20, 1970, and April 4, 1970. Those infants whose bilirubin level was at least 10 mg.% for full-term infants and 8 to 10 mg.% for low birth weight infants were admitted to the phototherapy room and randomly assigned to five therapy units. Rh-sensitized infants and babies with a positive Coombs test were excluded from participation in the study. Phototherapy was discontinued when the infant's bilirubin dropped below 10 mg.%

Each light therapy unit was composed of a bank of eight 40-watt fluorescent bulbs. Distance from the light source to the level of the baby measured 16 inches. Five commercially available fluorescent lights were selected for the study: cool white, high energy blue, CritiColor*, Vita-Lite** and Chroma 55***.

All infants were treated in incubators placed under the phototherapy unit. The Plexiglas incubators lessen ultraviolet transmission and otherwise do not interfere with phototherapy.[8] The infants were unclothed except for simple shields made of construction paper to cover the eyes.[9] In each twelve-hour period lights were discontinued for a one-hour interval. Every baby was turned several times a day to expose as much of the infant to the light as possible, and each received routine feeding and nursery care.

Bilirubin readings, both total and direct, were obtained twice daily during therapy. To evaluate

*North American Phillips, New York, N.Y.
**Duro-Test Corporation, North Bergen, N.J. 07047
***General Electric Lamp Division, Cleveland, Ohio 44112

Table 1. Clinical data of phototherapy subjects

Type of Light	Blue	Cool White	CritiColor	VitaLite	Chroma 55
TOTAL	20	20	20	20	20
Male	14	12	13	10	13
Female	6	8	7	10	7
RACE					
Negro	8	7	6	10	7
Latin American	10	10	4	6	6
White	2	3	10	4	7
BIRTH WEIGHT (gms.)					
1001-1500	—	—	—	1	—
1501-2000	—	—	—	1	—
2001-2500	—	3	3	2	6
2501-3000	5	5	1	4	5
3001 +	15	12	16	12	9
APGAR SCORE					
0-4	—	—	2	3	—
5-7	5	3	4	6	5
8-10	15	17	14	11	15
INFANTS WITH ABO INCOMPATIBILITY	3	4	1	5	5
MEAN HEMATOCRIT LEVEL	62.6	62.9	60.9	62.9	61.3

Table 2. Response to phototherapy of various groups of infants

MEAN VALUES

Subject Groups	Number of Newborns	Phototherapy (hrs.) Age At Onset	Phototherapy (hrs.) Duration	Bilirubin (mg.%) Initial	Bilirubin (mg.%) Peak	Bilirubin (mg.%) Final	Bilirubin (mg.%) Mean of Diff.
LOW BIRTH WEIGHT INFANTS*	14	81.1 (SE=2.84)	48.4 (SE=1.75)	11.8	12.1	7.9	3.81
TERM INFANTS*	68	68.7 (SE=2.73)	57.6 (SE=3.26)	12.3	12.6	8.0	4.44
Negro	24	71.2 (SE=2.64)	56.8 (SE=1.72)	11.7	12.0	7.9	3.95
Latin American	31	66.7 (SE=3.90)	59.3 (SE=4.52)	12.7	12.9	7.9	4.78
White	13	68.7 (SE=5.81)	56.9 (SE=8.94)	12.7	13.0	8.2	4.54
INFANTS WITH ABO INCOMPATIBILITY**	18	36.9 (SE=5.92)	77.4 (SE=9.01)	11.2	13.1	8.1	3.22

*Infants with ABO incompatibility are excluded
**Includes 16 term infants and 2 low birth weight infants

Age at Onset of Therapy:

Infants with ABO Incompatibility vs. Term Infants: t=4.48, p=0.001, VERY SIGNIFICANT

Low Birth Weight Infants vs. Term Infants: t=4.1, p=0.001, VERY SIGNIFICANT

Duration of Therapy:

Infants with ABO Incompatibility vs. Term Infants: t=2.1, p=0.05, SIGNIFICANT

Infants with ABO Incompatibility vs. Low Birth Weight Infants: t=2.85, p=0.01, SIGNIFICANT

the rebound phenomena, another bilirubin determination was made twenty-four hours after therapy ceased. The Diazo color development of the modified method of Evelyn and Malloy[10] was used.

Table 1 illustrates the composition of the population group undergoing phototherapy. Negroes and Latin Americans comprised 74% of the neonates requiring light treatment; 84 term infants and 16 low birth weight infants were included in the study. Of the 100 babies observed, 18 had ABO incompatibility. The hematocrit levels in the five groups were comparable with a mean range of 60.9 to 62.9.

Results

Patients were first divided into three groups: low birth weight infants (less than 2500 grams at birth), term infants, and infants with ABO incompatibility. Term infants were further categorized by race (Table 2). In low birth weight infants, phototherapy was initiated at a mean age of 81.1 hours, compared with term infants in whom treatment was started at 68.7 hours. Even though the less mature low birth weight infants began therapy at a statistically earlier age compared to the full-term infants, they responded equally well to phototherapy. It also was observed that infants with ABO incompatibility required significantly more hours of illumination and reached higher peaks of bilirubin. Treatment was unaffected by skin pigmentation. Rebound was minimal in our study; only six babies required a second period of therapy.

The response to phototherapy with the five different types of fluorescent lights is shown in Table 3. In our patient group, there was a decided drop in the hours of phototherapy required for the infants exposed to the full spectrum and blue fluorescent bulbs in comparison to the cool white lighting. There was a marked difference (18.8 hours) between the duration of therapy of the cool white bulb and that of the light which required the shortest amount of therapy, Criti-Color; there was a nine-hour difference between the poorest broad spectrum bulb and the cool white. No statistically significant difference was found between the duration of therapy required with any of the bulbs, however.

Discussion

Even though differences between the duration of therapy of these five bulbs is not significant, the data suggest that there is a correlation between the length of therapy and the spectral energy distribution curves of these lamps (Fig. 1). This curve explains the comparative inefficacy of the cool white light because its spectral emission pattern is concentrated in the yellow portion of the visible spectrum rather than the 400 to 500 nm. range. The broad spectrum bulbs, as well as the blue lamp, have higher radiant energy levels at the absorption spectrum of bilirubin than does the cool white fluorescent and showed correspondingly better results.

Although the exact breakdown products of bilirubin have not been identified, many in vitro studies of bilirubin exposed to light[11-14] suggest that peak absorption of some by-products of bilirubin is at a much higher emission spectrum than that required to decompose bilirubin. Since the blue fluorescent is confined to a relatively narrow band of the visible wavelengths, the broad spectrum bulbs may have an additive photodegradative action on by-products of bilirubin during photodecomposition.

Blue fluorescent lights, because of their spectral energy distribution curve, are widely used in phototherapy units. However, the visible intensity of the bulb, as well as the rapidity with which each fluorescent lamp decreases in light output with use need to be considered.

Figure 2 compares the light in footcandles of the five fluorescent lamps used in this study. The blue light is obviously inferior in its light intensity. Use of the blue fluorescent lighting during the study met with considerable objection on the part of nursing personnel. Cyanosis is difficult to recognize with this type of illumination.

A second consideration in choosing a lamp for a phototherapy unit is the rapidity with which each fluorescent light decreases in light output with use. The initial output is quite variable from bulb to bulb; for rating purposes the manufacturers use the 100-hour reading as the initial value.[15] The lumen maintenance curve shows a steady decline in light output as the burning hours are increased. Sisson[7] has reported a drop of 44 to 49% after 200 hours use of the blue fluorescent light in the 400 to 480 nanometer wavelength spectrum. Since this wavelength encompasses the action spectrum of bilirubin, the substantial loss of over 40% emitted energy probably has an adverse effect on the rate of drop of serum bilirubin.

Our findings correlated with the drop of 44 to 40% in radiant energy after 200 hours of use as reported by Sisson and co-workers.[7] However, measurement of the blue bulbs used in our study with a Zeiss monochromator† showed a loss of 20% in the 420 to 480 nanometer interval after only twenty-four hours of use. Testing of the other four fluorescent bulbs (CritiColor, Vita-Lite, Chroma 55 and cool white) showed no serious energy loss in the 420 to 480 nanometer area, as did the blue light; these lamps decreased in energy output uniformly throughout their spectral energy distribution curves.

Conclusion

Results demonstrate the superiority of broad spectrum fluorescent lights resembling the natural outdoor light of 5500° Kelvin. These lamps have acceptable energy representation in the spectrum of bilirubin degradation with no sharp drop-off values toward the longer wavelengths as found

†*Zeiss monochromator, Model MUQ II, with a PMQ II Detector*

Table 3. Response to phototherapy with different types of fluorescent lights
Mean Values

Type of Light	Number of Newborns	Duration of Therapy (hrs.)	Bilirubin (mg.%)			
			Initial	Peak	Final	Mean of Diff.
Blue	20	56.8 (SE=5.84)	11.7	12.4	8.0	3.64
Cool White	20	71.3 (SE=8.33)	12.7	12.8	8.0	4.70
CritiColor	20	52.5 (SE=5.41)	12.2	12.6	8.5	3.70
Vita-Lite	20	61.4 (SE=6.45)	11.7	12.3	7.3	4.44
Chroma 5	20	57.5 (SE=19.59)	12.1	13.1	8.2	3.83

in the narrow spectrum high energy blue fluorescent lights. Because the broad spectrum bulbs resemble the natural outdoor light of 5500° Kelvin more closely than do the blue fluorescents they are probably a more natural form of lighting. Blue lights have a further disadvantage in that they immediately start to decrease in energy output with a loss of 20% in the 420 to 480 nm. range after only 24 hours of use and a 40% and greater drop in that spectrum after 100 hours of use. Broad spectrum and cool white bulbs show no serious loss in the 420 to 480 nanometer area as did the blue light.

Summary

Five commercially available fluorescent lights were compared for their effectiveness in treating hyperbilirubinemia of the newborn. Lights with maximum representation in the 420 to 460 nanometer spectrum, the wavelength for photodecomposition of bilirubin appeared to be more effective as measured by the time required to lower serum bilirubin to safe and acceptable levels; the broad spectrum bulbs as well as the blue lamp showed correspondingly better results than the cool white fluorescent as measured in hours of therapy required.

Results demonstrate the superiority of broad spectrum fluorescent lights resembling the natural outdoor light of 5500° Kelvin. These lamps not only have acceptable energy representation in the spectra of bilirubin, but provide a more natural form of illumination and have a much longer bulb life than does the blue fluorescent. ◄

Acknowledgements

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The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Illinois Housestaff at Portland

December 1-4 of this past year, three Illinois housestaff physicians attended the AMA convention in Portland as guests of the Illinois State Medical Society. Representing Illinois housestaff were Paul Stromberg, M.D., first-year resident in surgery at Cook County Hospital; Michael Hughey, M.D., first-year resident in obstetrics and gynecology at Evanston Hospital; and Ron Staubly, M.D., first-year resident in family practice at Southern Illinois University. They attended the meetings of the Illinois delegation, the Interns and Residents Business Session, the many reference committee meetings, and the meetings of th House of Delegates.

This exposure to the national level of organized medicine was particularly valuable to these housestaff officers. Not only were they able to bring to the convention the feelings and attitudes of the many housestaff physicians in Illinois, but they returned to Illinois with greater knowledge of AMA affairs and effective action within organized medicine.

In his official report to the ISMS, Dr. Staubly summarized his own reaction to the convention and the significant events of the convention:

> "The month of December has traditionally brought holidays devoted to giving and receiving. During this month we have seen a similar exchange between housestaff and regular members of this association, albeit of sentiment and conviction rather than parcels or greetings.
>
> What was received by young physicians, specifically housestaff, was meaningful participation in this organization. Following the last session of the AMA House of Delegates, the housestaff members of this association found themselves with the following substantive gains: (1) abolition of the appointed housestaff advisory committee to the Board of Trustees; (2) the replacement of that committee with the elected leaders of the housestaff section (*ie.*, the Executive Committee of the Interns and Residents Business Session of the AMA); (3) a clear statement of editorial responsibility for the I and R Newsletter of the AMA; (4) a definite statement regarding assignment of priorities within the allotted budget of the I and R Business Session; (5) the distribution of reports developed by the I and R section for informational purposes with the understanding that these documents will represent official policy only after approval by an appropriate body of the AMA; and (6) the approval of a comprehensive set of housestaff contract guidelines.
>
> What was given by housestaff to the regular membership was an understanding of the seriousness and maturity of their convictions. The I and R section had a clear statement of purpose after its first meeting in Portland. This purpose was to secure, with the approval of the House of Delegates, certain basic franchises for this housestaff membership within the AMA. This purpose was realized.
>
> Furthermore, both friends and opponents of the housestaff associations within the AMA were given the committment for renewed effort to encourage and promote housestaff participation. Perhaps more importantly, the association was given the promise of the infusion of a previously largely untapped resource, the opinions and efforts of housestaff.
>
> As for what the near future may hold for housestaff within this association, I can only speculate. However, I think that it is important to emphasize that more than ever this association can and will function as the umbrella organization for American medicine in speaking to the issues of National Health Insurance, Health Manpower and Peer Review.
>
> The long-range implications of the Portland actions will in my opinion serve to create a productive forum for the development of the future leadership as well as membership of this organization. Moreover, this potentially vigorous housestaff section will facilitate the introduction of ideas from a different perspective.
>
> In conclusion, one can see that the Portland convention realized a more significant housestaff role in this organization with the promise of "new blood" which I feel can only contribute to its success and viability. Thus, I will take this opportunity to recommend to my fellow housestaff officers, with uncompromised conviction, membership in the AMA." ◄

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

CAIRO: FP/CARD/PUL/INT. wanted. Southern Ill. town of 6,500. Several office locations available. Modern community hospital, excellent opportunity for practice, education, public and private schools, Jr. college, and leisure; fishing, hunting, boating. Large cities nearby. Financial arrangements available. Contact Collect: Harvey Pettry, Padco Community Hospital, 2020 Cedar St., Cairo 62914 (618-734-2400) (3)

CARBONDALE: Family Practitioner wanted. Publicly funded out-patient clinic. 40 hour work week, plus liberal fringe benefits, salary open. Possible additional association: SIU Medical School; Emergency Medical Group; and/or thirty physician group practice. Contact: Geary Simmons, Director, Hays Center, 441 E. Willow St., Carbondale 62901 (618-549-0711). (5)

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CLINTON: Population 8,200. Needs physician, four physicians at present. Centrally located, 25 miles from larger cities. Office facility available at present. Hospital with 44 beds, all services. Recreational facilities. Civic organizations. Good schools and churches. Contact: Robert Myers, M.D., 219 E. Main, Clinton 61727, 217-935-5022. (5)

DECATUR: Emergency Physicians—work two out of five weeks. Under 55, good health, excellent command of English required. Back ground in GP and/or Surgery desirable. Some teaching involved. Established incorporate group on fee for service. Contact with 400 bed hospital—Emergency Department with excellent profit and pension benefits. CONTACT: DECA Ltd., 2300 N. Edward, Decatur 62526 (217-877-8121) (6)

DANVILLE: Population 42,600. Interest in friendly small community with cultural and metropolitan advantages of larger cities? Interested in practicing in the new ED with plenty of interesting and challenging work? Interested in excellent salary plus fringe benefits? Full-time position available. CONTACT: A. J. Evans, Administrator, Lake View Memorial Hospital, Danville 61832 (217-443-5345) (6)

EAST ALTON: Immediate opening for industrial physician to direct extensive medical program at East Alton plant (St. Louis area). Medical facility is one of the most modern and best equipped in industry. Compensation, benefits and area highly attractive. Contact: MacRoy Gasque, M.D., Health Affairs, Olin Corporation, 120 Long Ridge Rd., Stamford CT 06904. (5)

GENEVA: GP's. OB-GYN, Ped, Internists, outstanding area with excellent practice opportunity. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "New England" background—and all only 35 miles from the cultural and medical advantages of Chicago. Contact: L. C. Davis, Administrator, c/o Community Hospital, Geneva 60134 312-232-0771 (5)

HAVANA: Primary physicians needed. A central Illinois Community noted as a fishing and hunting paradise. 50 bed, fully accredited hospital with 25 room clinic adjacent. Guaranteed income for solo, duo or group practice serving an area population of 15,000. Contact: J. M. Dosher, Administrator, Mason District Hospital, 520 E. Franklin, Havana 62644 (309-543-4431) (3)

ILLINOIS—Variety of settings in agencies providing diagnostic, treatment consultative and advisory services or administrative direction to medical programs. Completion of approved Medical School and 1 year internship-residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—good benefits. Equal Opportunity Employer—Male or Female. Send resume to: R. P. Gosnell, Manager, Illinois Department of Personnel, 521 State Office Building, Springfield 62706 (4)

JOLIET: Pediatric psychiatrist to serve as consultant for the John F. Kennedy Diagnostic Clinic. Services include examination and evaluation of children ages 3 to 21; consultation with special education staff and teachers; consultant to classes for behavioral disorders. Contact: Mrs. S. Maxwell, Kennedy Diagnostic Clinic, 420 N. Raynor, Joliet 60435 (815-727-6431 x34) (3)

KEITHSBURG: Population 950—we need a doctor badly. We don't have a fancy office. A need of a doctor in three directions. 80 bed hospital—18 miles south in Aledo. Ambulance Service. Rock Island 45 miles away. Resort area on the Mississippi River. Good People . . . Contact: M. L. Stevens, Box 165, Keithsburg 61442 (309-374-2250) (3)

McHENRY: Immediate opening for Internists, Pediatrician, General Surgeon and Thoracic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one; fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: E. F. Wilt, Jr., M.D., McHenry Medical Group, 1110 N. Green St., McHenry 60050 (815-385-1050) (4)

NASHVILLE: Board certified or eligible surgeon - must be willing to do general practice - 3,000-14,000 - 72 bed JCAH hospital - 50 miles east of St. Louis - excellent schools and churchs - outstanding area to live - assistance available - Contact: T. K. Janssen, 603 South Grand Ave., Nashville 62263 (618-327-8236)

ODIN: Population 1,300. New medical facilities being installed. Two shelter care homes and small towns nearby without facilities. Hospitals: Centralia twelve miles and Salem five miles, approximately sixty five miles east of St. Louis medical facilities. Recreational facilities nearby. CONTACT: Rolland Devor, Jr., P.O. Box 215, Odin 62870 (618-775-8499) (3)

PINCKNEYVILLE: Population 3500—serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year —then partnership. Good recreational facilities near St. Louis. Contact: C. E. Cawvey, M.D., 206 North Main St., Pinckneyville 62274 (618-357-2131) (4)

WOODSTOCK: General Practioner or General Surgeon to join busy two man practice in Northwestern Illinois town of 15,000. New 130 bed general hospital with open staff. Large new office with 15 examining rooms, x-ray and lab facilities. Salary open, many fringe benefits, commensurable with training and experience. Contact: Dr. H. A. Stahlecker, 666 W. Jackson, Woodstock 60098 (815-338-2248 or 338-4666) (4)

LOW-COST GROUP INSURANCE
ANOTHER ISMS MEMBERSHIP PRIVILEGE

THE GROUP DISABILITY PLAN ● Provides up to $400.00 weekly in the event of disability caused by Accident or Sickness. ● Special Guaranteed renewal feature. ● Protect your income and security.

BUSINESS OVERHEAD EXPENSE PLAN ● Pays your office overhead expense when disability strikes. ● Premiums are Tax Deductible. ● Pays in Addition to the Disability Plan Benefits.

THE FAMILY MAJOR MEDICAL EXPENSE PLAN ● In or out of Hospital Benefits up to $25,000.00 per Disability. ● Up to $100.00 Daily Hospital Room and Board maximum ● Subject to choice of deductible and 80% coinsurance.

FOR INFORMATION, ASSISTANCE & DETAILS CONTACT:

Administrators:

PARKER, ALESHIRE & COMPANY
ESTABLISHED 1901
Insurance

9933 N. Lawler Avenue
Skokie, Illinois 60076
Phone: 312-679-1000

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
360 No. Michigan Ave. • Chicago, IL 60601 • (312) 782-1654

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

March, 1975

Alcoholism

ALCOHOLISM
For: MDs. Lecture, March 4, Chgo. **Speaker:** S. Nieder, MD, Dir./Alcoholic Treatment Unit, Martha Washington Hosp. **Sponsor:** Chgo. Med. Soc., N. Shore Branch. **Contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chicago 60618.

Anesthesia

ELECTROCARDIOGRAPHY FOR ANESTHESIOLOGISTS
For: MDs. 5-day Course, March 3-7, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
REGIONAL ANESTHESIA & THERAPEUTIC NERVE BLOCKING
For: MDs. 5-day Course, March 10-14, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $300. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Basic Science

CLINICAL IMMUNOLOGY OF SERUM PROTEIN CHANGES
For: MDs, Paramedics, Nurses, etc. Seminar, March 11, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp./DuPage County, Avon & Schiller St., Elmhurst, IL 60126. **Co-sponsor:** Behring Diagnostic—Division of Hoechst Pharm. Co.
DIGITALIS INTOXICATION
For: MDs, Paramedics, Nurses, etc. Seminar, March 4, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp./DuPage County, Avon & Schiller St., Elmhurst, IL 60126.

Bronchoesophagology

COURSE IN LARYNGOLOGY AND BRONCHOESOPHAGOLOGY
For: Residents or MDs of Otolaryngology. 6-day Course, Chgo. **Speaker:** P. Holinger, MD, Dir./Otolaryngology. **CME Credit:** 45 hrs., AMA Cat., 2. **Fee:** $300. **Reg. Limit:** 20. **Sponsor, contact:** Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

General Medicine

TUBERCULOSIS
For: MDs & Nurses. Lecture, March 26, Chgo. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.
MALABSORPTION SYNDROME
For: MDs & Nurses. Lecture, March 19, Chgo. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.
GENERAL MEDICINE LECTURE SERIES
For: House Staff & Gen. Staff. Wkly. Lecture Series, March 4, 11, 18, 25, Chgo. **CME Credit:** 18 hrs., AAFP Elective. **Sponsor, contact:** A. Sapienza, MD, Dir./Med. Ed., St. Mary of Nazareth Hosp. Center, 1120 N. Leavitt St., Chgo. 60622.

Geriatrics

RECENT ADVANCES IN GERIATRIC MEDICINE
For: All MDs. 1-day Course, March 8, Chgo. **CME Credit:** 8 hrs., AMA Cat. 1. **Fee:** $50. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Glomerulonephritis

RECENT ADVANCES IN GLOMERULONEPHRITIS
For: MDs & Nurses. 4th Annual Lecture, March 12, 11:00 am, Chgo. **Speaker:** D. Earle, MD, Prof./Med., Northwestern Medical Sch. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir., Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.

Internal Medicine

BASIC ELECTROCARDIOGRAPHY
For: MDs. 5-day Course, March 3-7, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 35. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
ONE WEEK COURSE IN BASIC INTERNAL MEDICINE
For: MDs. 5-day Course, March 17-21, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 50. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neurology

NEUROLOGY, PART I, BASIC
For: All MDs. 5½-day Course, March 17-22, Chgo. **CME Credit:** 44 hrs., AMA Cat. 1. **Fee:** $200. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
REVIEW COURSE IN NEUROPATHOLOGY
For: Neurologists. 5½-day Course, March 10-15, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $225. **Reg. Limit:** 30. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neuromuscular Disease

NEUROMUSCULAR DISEASE: CURRENT IDEAS IN DIAGNOSIS AND MANAGEMENT
For: All MDs. Second Wednesday of Month, March 12, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** Ms. E. Ehrman, Adm. Asst., U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

Neurotology

NEUROTOLOGY
For: Residents or MDs of Otolaryngology. 4-day Course, March 24-27, 9:00-5:00, Chgo. **CME Credit:** 25 hrs., AMA Cat. 2. **Speaker:** N. Torok, MD, Prof. of Otolaryngology, Dir. of Course. **Sponsor, contact:** Ms. W. Wickland, Adm. Sec., Dept./Otolaryngology, U. of IL, 1855 W. Taylor St., Chgo. 60612.

Ophthalmology

ANNUAL OPHTHALMOLOGY ALUMNI DAY, U. OF CHGO. DEPT. OF OPHTHALMOLOGY
For: Ophthalmologists. Day-long Lecture, March 5, Chgo. **Sponsor, contact:** J. T. Ernest, MD, Assoc. Prof./Ophth., U. of Chgo. Dept. of Ophthalmology, 950 E. 59th St., Chgo. 60637.

Psychiatry

CHILD PSYCHIATRY FOR PEDIATRICIANS
For: Pediatricians. Seminar, March 5, 12, 19, 26, Chgo. **Sponsor, contact:** A. Khan, MD, Div./Child Psych., Children's Memorial Hosp., 2300 Children's Plaza, Chgo. 60614.

Psychotherapy

SEXUAL AND MARITAL PROBLEMS—BRIEF PSYCHOTHERAPY
For: MDs, Psychologists, Mental Health Workers. Conference, March 21, 8:30 am—7:00 pm, Pick Congress Hotel; March 22, 9:00 am—12:00 noon, The Chgo. Med. Sch., Chgo. **CME Credit:** 8 hrs., AMA Cat. 1. **Fee:** $75. Deadline: March 14. **Sponsor, contact:** J. Cowen, Dept. of Psych. & Behavioral Sciences, U. of Health Sciences/The Chgo. Med. Sch., 2020 W. Ogden Ave., Chicago, IL 60612.

Recent CME Accreditations

The ISMS Committee on CME Accreditations has recently approved the CME programs of these institutions:

John J. Madden Zone Center, Hines

Memorial Hospital, Mattoon

Resurrection Hospital, Chicago

St. Elizabeth Hospital, Granite City

St. Mary of Nazareth Hospital, Chicago

St. Therese Hospital, Waukegan

Southern Illinois Medical Association, Belleville

Westlake Community Hospital, Melrose Park

Respiratory Care

PULMONARY EMBOLI
For: All MDs. Symposium, March 25, 8:00 AM, Melrose Pk, IL. **CME Credit:** 1½ hr., AMA Cat. 1. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp., 1225 Superior St., Melrose Park, IL 60160.

Surgery

PEDIATRIC SURGERY
For: Pediatricians. Monthly meeting, March 18, Highland Park Country Club, Highland Park, Ill. **Fee:** Dinner Reservations, $12; social hr., 6:00 pm, dinner 7:00 pm, program, 8:00 pm. **Sponsor:** Chgo. Pediatric Society. **Contact:** L. M. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

RECONSTRUCTIVE ORTHOPEDICS
For: All MDs. Symposium, March 19, Holiday Inn of Glen Ellyn. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** DuPage County Med. Society, 646 Roosevelt Rd., Glen Ellyn, IL 60137.

PRE AND POSTOPERATIVE CARE OF PATIENTS FOR SURGEONS & SURGICAL SPECIALISTS
For: Surgeons and Surgical Specialists. 4-day Course, March 4, Chgo. **CME Credit:** 31½ hrs., AMA Cat. 1. **Fee:** $175. **Reg. Limit:** 80. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo., IL 60612.

Trauma

TRAUMA
For: All MDs. Lecture, March 18, 7:30 PM, Elgin, IL. **CME Credit:** 2 hrs., AMA Cat. 1. **Sponsor, contact:** CME Comm. of Sherman Hosp., 934 Center St., Elgin, IL 60120.

CLINICAL HOSPITAL PROGRAM ON GENERAL SURGERY TRAUMA
For: All MDs, Residents & Interns. 2-hr. Eve. Clinical Prog., March 18, Christ Comm. Hosp., 4440 W. 95th St., Oak Lawn; Lutheran Gen. Hosp. 1775 Dempster, Pk. Ridge, IL. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the AM. Coll. of Surgeons, 11255 W. 74th St., LaGrange, IL 60525.

Urology

ADVANCES IN UROLOGY
For: Urologists. 2-day Course, March 3-4, Chgo. **CME Credit:** 16 hrs., AMA Cat. 1. **Fee:** $80. **Reg. Limit:** 25. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chicago, IL 60612.

APRIL, 1975

Basic Sciences

STATE AND NATIONAL BOARD REVIEW COURSE, BASIC
For: All MDs. 6½ day-Course, Apr. 27-May 3, Chgo. **CME Credit:** 58 hrs., AMA Cat. 1. **Fee:** $225. **Limit:** 85. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Cancer

AGRESSIVE TREATMENT OF CANCER: REWARD AND RISKS
For: MDs. 2nd Wed. of Mo., Apr. 9, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.
BREAST CARCINOMA
For: All MDs. Short Course, Apr. 23, Gary. **CME Credit:** 6 hrs., AMA Cat. 1, AAFP. **Fee:** $35. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U. Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

Cardiology

HEART DISEASE 1975
For: GPs, Interns, RNs. 2-Day Wkshp., Apr. 18-19, Giant City State Park Lodge, Makanda, IL. **CME Credit:** 6 hrs., AAFP Applied for. **Fee:** $30 MDs, $15 RNs. **Sponsor, contact:** IL. Heart Assoc., Professional Ed. Council, 1007 W. Mill St., P.O. Box 3496. Carbondale, IL 62901.

Clinical Practice

COMMON LEGAL PROBLEMS IN CLINICAL PRACTICE
For: MDs & Nurses. Lecture, Apr. 16, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Family Medicine

BASIC GYNECOLOGY
For: All MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Family Practice Therapy

WORKING WITH PROBLEM FAMILIES
For: Family Physicians & Family Therapists. 2-Day Seminar, Apr. 25-26, Holiday Inn, Oak Brook Terrace, Villa Park, IL. **CME Credit:** 11 hrs, AAFP Elective. **Fee:** $75. **Sponsor, contact:** Family Practice Cntr., MacNeal Memorial Hosp., 3249 S. Oak Park Ave., Berwyn, IL 60402.

General Interest

"PRACTITIONERS & PROFESSORS: PARTNERS IN CME"—3rd ILLINOIS CONGRESS ON CME
For: All interested in CME. Conference/workshop, Apr. 18-19, Chateau Louise, Dundee, IL. **CME Credit:** 9 hrs., AMA Cat. 1. **Fee:** $35. **Limit:** 100. **Sponsor, contact:** IL Council on CME, 360 N. Michigan Ave., Chgo. 60601.

Immunology

IMMUNOLOGY
For: All MDs. Course, April 30, 8:00 AM, Melrose Pk, IL. **CME Credit:** 8 hrs., AMA Cat. 2. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp., 1225 Superior St., Melrose Park, IL 60160.

Internal Medicine

FAMILY PRACTICE REVIEW
For: All MDs. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
ADVANCES IN MEDICINE
For: Internists. 5-day Course, Apr 28-May 2, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neurosurgery

DIAGNOSIS OF A BRAIN TUMOR
For: MDs & Nurses. Lecture, Apr. 30, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Speaker:** L. Yarzagaray, MD, Asst. Prof/ Neurosurgery, Loyola U. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Pediatrics

ADVANCES IN NEONATOLOGY
For: Pediatricans. 2-day Course, Apr. 21-22, Chgo. **Fee:** $75. Sponsor, contact: Ck. Cnty. Grad. Sch./ Med, 707 S. Wood St., Chgo. 60612.
RESIDENTS' COMPETITION
For: Pediatricians. Monthly Mtg., Apr. 15, Social Hr.—6:00 pm., Dinner—7:00 pm, Program— 8:00 pm, Mercy Hosp. & Med. Cntr., Chgo. **Fee** Dinner $12/ea. **Sponsor:** Chgo Pediatric Society, **Contact:** L. M. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.
SPECIALTY REVIEW COURSE IN PEDIATRICS
For: Pediatricians. 5½-day Course, Apr. 7-12, Chgo. **CME Credit:** 38 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Psychiatry

CHILD AND ADOLESCENT NORMAL DEVELOPMENT AND BEHAVIOR PROBLEMS
For: MDs. 5-day Course, Apr. 28-May 2, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
MANIC-DEPRESSIVE ILLNESS: HISTORY OF A SYNDROME
For: Psychiatrists. Wkly. Seminar, Apr. 2, 9, 16, 23, 30,/5:00-6:30 pm. Chgo. **CME Credit** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601
PSYCHOANALYTIC PSYCHOLOY
For: Psychiatrists. Wkly. Seminar, Apr. 7, 14, 21, 28./6:30-8:00 pm. Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125 **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601.
THE RELATIONSHIP OF THEORY TO THE CLINICAL PRACTICE OF PSYCHOTHERAPY
For: Psychiatrists. Wkly. Seminar, Apr. 3, 10, 17, 24, 6:30-8:00 pm, Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Michigan Ave., Chgo. 60601.
CLINICAL ASPECTS OF DELINQUENCY AND CRIMINALITY
For: Psychiatrists. Wkly. Seminar, April 3-June 5, 8:00-9:30 AM, Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** J. Palombo, Co-Chmn., Cont. Ed. Comm., Inst./Psychoanalysis, Cont. Ed. Prog., 180 N. Mich. Ave., Chgo. 60601.

Radiology

CHEST RADIOLOY
For: Radiologists. 3-day Workshop, Apr. 23-25, Indianapolis. **CME Credit:** 21 hrs., AMA Cat. 1, AAFP. **Fee:** $125. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U Sch/Md., 1100 W. Michigan, Indianapolis, IN 46202.
DIAGNOSTIC RADIOLOGY
For: MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Science

GERIATOLOGY
For: MDs, paramedics, Nurses, etc. Wkly. Seminar, Apr. 8, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp./DuPage County, Avon & Schiller St., Elmhurst, IL 60126.

Surgery

BLOOD VESSEL SURGERY
For: Surgeons. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $300. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day Course, Apr. 28-30, Chgo. **CME Credit:** 19½ hrs, AMA Cat. 1. **Fee:** $250. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
SURGICAL ANATOMICAL REVIEW
For: Surgical Residents. Month-Long Course, Ann Arbor. **CME Credit:** 105 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $300. **Sponsor, contact:** R. K. Richards, Dir., Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.
SURGERY OF GASTROINTESTINAL TRACT
For: Surgeons. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, Interns, 2-hr. Eve. Clinical Prog., Apr. 15, LaGrange Comm. Memorial Hosp., 5101 S. Willow Sprngs. Rd., La Grange, IL. **CME Credit:** 2 hrs., M Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons, 11255 W. 74th St., LaGrange, IL. 60525.

May, 1975

Cardiology

HYPERTENSION
For: All MDs. Symposium, May 13, 8:30 AM, Melrose Pk, IL. **CME Credit:** 1½ hrs., AMA Cat. 2. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp. 1225 Superior St., Melrose Park, IL 60160.

Dermatology

For: Dermatologists. 5-Day Course, May 5-9, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

General Medicine

STATE & NATIONAL BOARD REVIEW COURSE, CLINICAL
For: All MDs. 6-Day Course, May 14-19, Chgo. **CME Credit:** 52 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Internal Medicine

ADVANCED CARDIOLOGY
For: Cardiologists. 5-Day Course, May 19-23, Chgo. **contact:** Cook County Grad. Sch./Med., 707 S. Wood **CME Credit:** 30 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor,** St., Chgo. 60612.
INTERMEDIATE ELECTROCARDIOGRAPHY
For: All MDs. 2-Day Course, May 8-9, Chgo. **CME Credit:** 14 hrs., AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING
For: Internists. 6-Day Course, May 12-17, Chgo. **CME Credit:** 60 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Medical/Legal Problems

MEDICAL/LEGAL PROBLEMS
For: MDs. Second Wed. of Mo. May 14, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

Musculo-Skeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, & Interns. Eve. Clinical Program, May 8, Michael Reese Hosp., 2929 S. Ellis, Chgo. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons. 11255 W. 74th St., LaGrange, IL 60525.

Pediatrics

COMMON GENETIC DISEASES
For: Pediatricians. 5-Day Course, May 19-23, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1.**Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
NO TITLE AVAILABLE—ANNUAL DINNER MEETING
For: Pediatricians. Regular Annual Dinner, May 21, Ambassador West Hotel. Dinner: $12, Social Hr.-6:00 PM. Dinner-7:00 PM. **Sponsor:** Chicago Pediatric Society. **Contact:** L. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

Radiology

REFRESHER COURSE IN RADIATION SCIENCE FOR THE RADIOLOGIST
For: Radiologists. 7-Day Course, May 19-25, Chgo. **CME Credit:** 59 hrs., AMA Cat. 1. **Fee:** $330. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Surgery

ADVANCES IN SURGERY
For: Surgeons. 5-Day Course, May 12-16, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
SURGERY
For: Ophthalmologists & Residents. Lecture & Symposium, May 23-24, Drake Hotel, Chgo. **CME Credit:** 12 hrs. AMA Cat. 1. **Fee:** $100. Sponsor, contact: Chgo. Ophthalmological Society, 1206 Oakwood Dr., McHenry, IL 60050.

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High Nitrate Community Water

(Continued from page 157)

enrollment. All others had a range varying from 2.3% decrease to a maximum of 9.5% increase. Health data were available for the years 1965-1966.[8]

Summary

Data were analysed as stated above, as well as by the covariance analysis method, for nitrate level effects by each sex and for sex by each nitrate level. The F test with 5% and 1% levels of confidence was used for the significance testing. As expected, there was a difference between sexes.

Of major significance is that the available data shows no demonstrable lethal effect of ingestion *during pregnancy* of community water containing "excess" nitrate upon infant mortality or fetal deaths. This fact should be of importance when a regulation for community or private water supplies as it pertains to maximum permissable nitrate concentration is formulated. ◄

References

1. Winton, E. F., Tardiff, R. G., McCabe L. J.: "Drinking water," *Am. W. W. Assoc. Jr.*, 63:95, Feb., 1971.
2. Shuval, H. T., and Gruener, N.: "Epidemiological and Toxicological Aspects of Nitrites and Nitrates in the Environment," *Am. J. Pub. H.*, 62:1045, Aug., 1972.
3. Jaffe, E. R.: "Hereditary Methemoglobinemias associated with Abnormalities in Metabolism of Erythrocytes," *Am. Jr. Med.*, 11:786, 1966.
4. Nitrates, Nitrites and Methemoglobinemia: National Institute Envir. Health Sc., 1970 Research, Tri Park, N. C.
5. Gelperin, A., Jacobs, E. E., and Kletke, L. S.: "The Development of Methemoglobin in Mothers and Newborn Infants from Nitrate in Water Supplies," *Ill. Med. Jr.*, 141:78, 1971.
6. Larson, T. E.: "Interim Report on the Presence of Nitrate in Illinois Surface Waters," Chemistry Section, Illinois State Water Survey Bureau, Urbana, Illinois, 1966.
7. Data Processing Dept., Illinois Department of Public Health, Springfield, Ill.
8. Inventory of Maternal & Child Health Resources, Jan., 1970, Illinois Department of Public Health, Springfield, Ill.

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Obituaries

*Cardon, Leonard, Chicago, died Dec. 3, at the age of 70. Dr. Cardon graduated from Rush Medical College in 1929.

*Cella, Louis, Elmwood Park, died Jan. 8, at the age of 70. He graduated from Loyola University in 1927.

*Coleman, Clement, Evanston, died Dec. 22, at the age of 62. Dr. Coleman graduated from the University of Illinois in 1936.

*David, Jones, Evanston, died Dec. 16, at the age of 53. Dr. David graduated from Havana University in 1949.

**Del Beccaro, Edward, Chicago, died Dec. 24, at the age of 88. He graduated from Northwestern University in 1914. Dr. Del Beccaro had practiced medicine for more than 50 years.

*Goal, George, Chicago, died Oct. 6, at the age of 76. Dr. Goal graduated from a medical school in Hungary in 1923.

*Hamilton, Robert, Libertyville, died Dec. 3, at the age of 47. Dr. Hamilton graduated from Northwestern University in 1953.

*Haniszko, Julius, Chicago, died Oct. 17, at the age of 56. He graduated in Pecs, Hungary in 1943.

*Kaippel, Ernest, Tinley Park, died Jan. 5, at the age of 64. Dr. Kaippel graduated from Elizabeth University in 1944.

*Kaufman, Ludwig, Blue Island, died Jan. 10, at the age of 77. He graduated from the Heidlberg in Wurttenberg, Germany in 1922.

*Kuehn, Edward, Vandalia, died Dec. 20, at the age of 69. Dr. Kuehn graduated from the University of Chicago in 1934. Dr. Kuehn was secretary of the Fayette County Medical Society.

*Marquis, Neal, Arizona, died Dec. 13, at the age of 74. He graduated from Loyola University in 1930. Dr. Marquis practiced medicine in the Sterling area and was one of the founders of the Sterling-Rock Falls Clinic.

*McLean, Dan, Elk Grove, died Jan. 12, at the age of 71. He graduated from the University of Illinois in 1920.

**Moffett, Reuben, Knoxville, died Jan. 15, at the age of 82. Dr. Moffett was President of the Knox County Medical Society.

**Narrod, Samuel, Chicago, died Jan. 12, at the age of 79. Dr. Narrod graduated from the University of Illinois in 1920. He has practiced medicine for more than 50 years.

*Norfray, Raymond, Glenview, died Dec. 10, at the age of 62. He graduated from Stritch Medical School in 1939.

*Rubenstein, Boris, Chicago, died Jan. 1, at the age of 67. He graduated from the University of Chicago in 1933. Dr. Rubenstein was an endocrinologist who conducted pioneering research into the psychobiology of women.

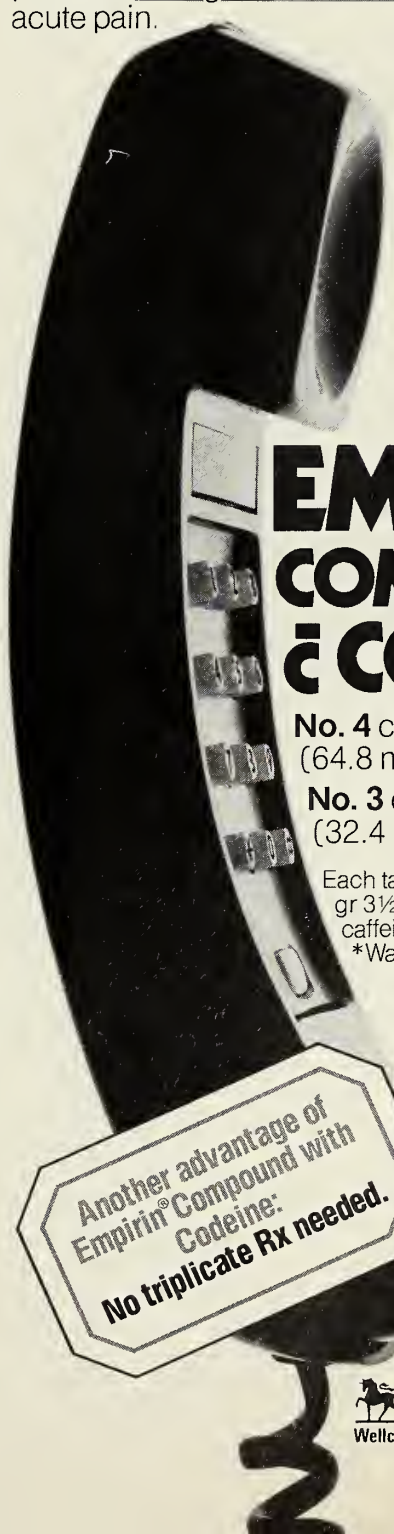
**Sauer, Henry, Fairbury, died Dec. 3, at the age of 89. He graduated from Rush Medical School in 1918. Dr. Sauer was past president of the Livingston County Medical Society. He also practiced medicine for more than 50 years.

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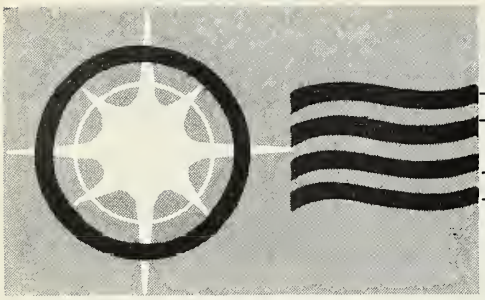
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membership forum

Dear Editor:

In the August issue of the Illinois Medical Journal Dr. Harvey Kravitz made some rather broad statements concerning the banning of the trampoline from schools.

Dr. Kravits stated that the Accident Prevention committee of the American Academy of Pediatrics has "gone on record in support of Dr. Walter Stolov's stand. . . ." A recent letter from the academy does not use language so strong. In fact they say no official stand has been made. I can find no published or written document or paper presented by either Dr. Walter Stolov or Dr. Robert G. Scherz. A Medline Search has turned up similar data, i.e., NOTHING.

Upon what does Dr. Kravitz base his information? The doctors in the Radiology Department of St. Elizabeth's Hospital have asked me to obtain such information, as the local school boards are asking for an "official" recommendation.

I am enclosing the letter from the American Academy of Pediatrics. Your help in this matter would be greatly appreciated. I look forward to hearing from you soon.

Sincerely,
Suzan A. Brame
Medical Librarian
Belleville, Ill.

Drug Substitution

Traditionally, physicians, dentists and pharmacists have worked cooperatively to serve the best interest of patients. Productive cooperation has been achieved through mutual respect as well as a common concern for the ideals of public service. This mutual respect has been reflected, in part, by joint support over the years for the adoption and enforcement of laws and regulations specifically prohibiting unauthorized substitution and encouraging joint discussion and selection of the source of supply of drug products. The basic principles of medical, dental and pharmacy practice are thus utilized and preserved in the interest of patient welfare. (Joint Position Statement-Antisubstitution of Drugs. *The Internist* [Oct] 1974, pg. 3.)

Dear Doctor Van Dellen:

This letter is in reply to Ms. Suzan A. Brame of St. Elizabeth Hospital, Chicago, Illinois.

The Accident Prevention Committee of the American Academy of Pediatrics in our spring meeting in 1974 endorsed Doctor Stolov's recommendation to ban the trampoline as a sport in the public schools. The Washington Chapter of the American Academy of Pediatrics has also made the same recommendation. As a member of the Accident Prevention Committee I have written the editorial affirming this position.

Sincerely,
Harvey Kravitz, M.D.
Member, Accident Prevention Committee
American Academy of Pediatrics

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BLUE SHIELD REPORT FOR Illinois Physicians

Spring Schedule of Workshops Planned for Medical Assistants

Arrangements are being completed for the Spring series of workshops for medical assistants in central and downstate counties beginning in April, sponsored by the Blue Shield Plan of Illinois Medical Service.

The daytime workshop programs to be held in April, May and June will consist of morning and afternoon sessions. Registration for the morning meetings will begin at 9:30 AM and the workshops will continue until noon. Luncheon will be served for all participants attending either the morning or afternoon program. Afternoon sessions will begin at 1:30 PM and conclude at 4:00 PM.

Members of our Professional Relations Department will conduct the meetings. Discussions and instructional material will cover Blue Shield programs, with emphasis on utilization of information in our recently published "Medical Assistants' Handbook," and completion of the Physician's Service Report form, particularly for members enrolled in our special programs and large national accounts.

Ample time will again be set aside for questions and answers. The workshops will be organized into groups of not over 20 participants, with an instructor assigned to each group. Special attention will be given to the newly-employed assistant with less than a year's experience.

Letters of invitation are being sent to physicians' offices in central and downstate counties this month, enclosing a reservation form. For additional information, please write or telephone Mrs. Loretta O'Donnell, Professional Relations Department, Blue Shield Plan of Illinois Medical Service, 233 North Michigan Ave., Chicago, Illinois 60601. Telephone (312) 661-2964.

SCHEDULE OF WORKSHOPS

Wed., April 2	Ramada Inn	Mt. Vernon
Thurs., April 3	Ramada Inn	Marion
Wed., April 9	Augustine's	Belleville
Thurs., April 10	Holiday Inn	Edwardsville
Wed., April 16	Ramada Inn	Champaign
Thurs., April 17	Ramada Inn	Effingham
Wed., April 23	Holiday Inn	Mattoon
Thurs., April 24	Holiday Inn	Decatur
Wed., April 30	Ramada Inn	Quincy

(The schedule of May and June workshops will be published in April issue of the "Blue Shield Report").

Your Help Needed in Reducing Payment Delays

Your assistance is needed to help us reduce delays in claims processing and provide accurate payment of benefits.

(1) Please submit claims promptly. An unusually long delay in submitting a Physician's Service Report following the last date of service is a significant factor in delaying the processing of a claim and increasing payment cycle time.

(2) Illegible handwritten Physician's Service Reports are difficult to process. When completing a Physician's Service Report, *please print or type* the necessary information. Our Blue Shield claims department processes an average of 6,000 claims daily; if the name of the patient or group and subscriber number is not clear, the claim is delayed until the information can be verified.

(3) To establish whether the patient is entitled to benefits, *we must* have an accurate "Group and Subscriber Number." Also, check for correct spelling of the patient's name and subscriber's name. If any of these items are incorrect, the claim is delayed. Copy this information from the Blue Shield membership card whenever possible.

(4) Please complete data on the sex, age, marital status of the patient and relationship of the patient to our member. Any of these omissions will delay the claim until such information can be obtained.

ASK BLUE SHIELD
. . . ABOUT MEDICARE

Accepting Assignment of Medicare Benefits

When assignment is taken, the physician and his patient agree to have Medicare make payment of benefits directly to the physician. The physician must submit an SSA-1490 Request for Medicare Payment form, agree to accept the reasonable charge as determined by Part B Medicare as *payment in full* and not bill patients for any difference between the amount he billed and the amount the Part B carrier allowed as the reasonable charge reimbursement.

The Part B carrier will pay 80% of the reasonable charge over and above the $60 deductible. The patient is responsible for 20% of the allowable charge (20% coinsurance), any amount applied to the Part B deductible, and any charge for services disallowed as non-covered.

Waiver Provision Affects Assignment Claims

In appealed claims that were disallowed for lack of medical necessity, and where the carrier determined that the physician could reasonably have been expected to know that such services are not covered by Medicare, the physician *cannot* bill the patient for such services and should, in fact, make refund of such amount already collected. (See "Limitation on Liability of Beneficiary and Physician": October thru December 1974 issues of "Ask Blue Shield About Medicare," Illinois Medical Journal. The series describes other circumstances covered by the Waiver provision of the Medicare Act, where denial of payment for non-covered services may be waived for the physician; or Medicare payment made when it is found that neither physician or beneficiary knew, or could reasonably be expected to know the services furnished were non-covered. Further clarification of the new regulations will be published in subsequent issues of the Blue Shield Report in IMJ).

The patient should sign Item number 6 in the claim form; and the physician should complete Part II and check the box in Item 12: "I accept assignment," otherwise payment will be made to the patient.

When Patient's Signature is Not Required

Signature of the patient must appear on the SSA-Request for Medicare Payment form except under any of the following circumstances:

(1) When a patient requires treatment over an extended period of time, the patient's signature is not required each time the physician bills the carrier. The physician obtains the patient's consent to assignment of unpaid charges for the anticipated period of treatment by having him sign a brief statement that would read essentially as follows:

"I request that payment under the medical insurance program be made directly to Dr. _____ _____ on any unpaid bills for services furnished me by that physician during the period _____ to _____."

The period should extend no longer than the close of the calendar year, and the statement should be attached to the original claim and be submitted in the usual manner. On subsequent claims, the physician should indicate: "This is a continuation of a course of treatment for which the patient's assignment was previously obtained." This statement should appear in the signature box.

New IDPA-Medicare Procedure

(2) When the patient is a public aid recipient he is not required to sign claim forms. The Illinois Department of Public Aid case identification number should be included in the block labeled "Policy or Medical Assistance number." The initials "IDPA" should be entered on the patient's signature line and "Illinois Department of Public Aid" in item 5 of the SSA-1490 form.

The physician should complete the SSA-1490 form in the usual manner, including the item indicating acceptance of assignment. When the claim is processed, the Part B carrier will send the physician a copy of the Explanation of Medicare Benefits (EOMB) which he can staple to his Public Aid claim and send to the Department of Public Aid office in Springfield for processing.

(3) When a patient is unable to sign the claim form because of a mental or physical condition, the patient's name is shown on line 6 of the form, followed by the word "by" and the signature and address of the relative or approved representative explaining his relationship to the patient. A statement is also needed explaining why the patient was unable to sign the request.

(4) If a person cannot write his name, he may sign with the mark (x) on the signature line, but the name and address of a witness must also appear on the line.

(5) When a patient is deceased and the physician accepts assignment, line 6 may be completed by the physician indicating "Patient is deceased."

(6) Where the carrier has approved the use of machine billing, it is acceptable on assignment claims if a signed consent statement is obtained once a month from the beneficiary and kept on file for possible carrier audit. In such cases the signature box of the SSA-1490 form should contain the entry "Signature on file."

IMJ

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Abstracts of Board Actions

January 19-21, 1975 **Washington, D.C.**

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. It covers only major actions and is not intended as a detailed report. Full minutes of the meetings are available upon any member's request to the headquarters office of the ISMS.

Liability Insurance Rate Increase Approved

To assure continued professional liability insurance for Illinois physicians at a time when MDs in other states are threatened by a loss of coverage, the Board of Trustees voted unanimously to amend the ISMS-Hartford contract, effecting a substantial increase in the professional liability insurance rates. The increase is effective July 1, 1975.

The original contract provided for limited premium increases each year for the first four years of the program. However, because of the recent drastic increases in the frequency and severity of claims, it became necessary to waive this restriction or the entire program would be placed in jeopardy.

Medical Liability Legislation

In a related action, the Board approved in principle—and referred to the Executive Committee—a series of Medical-Legal Council recommendations for alleviating professional liability problems of physicians. They include:

1. Development of legislation to create a medical injury compensation commission which would provide for equitable settlement of medically-related injuries (Workmen's Compensation-type).
2. Proposals for remedial legislation that might be utilized in lieu of a total new system for handling liability cases.
3. Legislation to provide for linkage between professional liability and proposed legislation to create a Medical Disciplinary Board to enforce licensing requirements.
4. Sponsorship—if necessary—of a House of Delegates resolution urging voluntary contributions to finance appropriate lobbying activity to accomplish legislative objectives.
5. Convening a top level meeting with chief officers of the Illinois Hospital Association, Illinois State Bar Association, Illinois Dental Society, representatives of the judiciary, major underwriters and other professional groups concerning this problem.

The Executive Committee was instructed to proceed expeditiously so that appropriate legislation can be introduced in the current session of the General Assembly.

The Board also authorized the Public Relations staff to encourage selected members of the news media to examine the problems of rising professional liability insurance rates and to provide them with background information compiled by the Medical Legal Council.

Other Legislation

The Governmental Affairs Council was authorized to seek legislation to:

1. Provide Illinois with a medical examiner system in accordance with a revised bill prepared by the Forensic Medicine Committee.
2. Exempt from rate review all physicians' compensation or fees which relate to the practice of medicine whether or not that practice occurs by virtue of employment or any other contractural arrangements with a health facility.
3. Strengthen the medical disciplinary system in Illinois, coordinating it with proposed medical maloccurance legislation.
4. Amend the Hospital Service Plan Act to provide for the classification of surgical centers by Illinois Blue Cross in a separate category from hospitals for reimbursement purposes. Present Blue Cross policy limits surgi-

center payments to cost plus 5% (the hospital formula) even though surgicenter costs are considerably less than those of hospitals.

Proposals to eliminate drug prescription misuse by amending the Medical Practice and Controlled Substances Acts were endorsed and referred to the Executive Committee for consideration along with other medical disciplinary matters.

The Board approved for introduction in the Legislature a resolution aimed at promoting the specialty of family practice in all Illinois medical schools receiving state or federal funds. The resolution calls upon schools to annually report their promotional activities on behalf of family practice to the Board of Higher Education.

The Board also indicated that ISMS—upon appropriate documentation of their harmful effects—will oppose changes in the Controlled Substances Act as proposed by the Illinois Legislative Investigating Commission and support several measures to enhance patient confidentiality.

Contingent upon acceptance by the Illinois Nurses Association, the Board agreed to support a proposed amendment to the Nursing Practice Act. The proposed amendment would legitimize performance of common nursing duties which could be considered illegal under the present Act and would prohibit nurses from performing any act clearly within the province of the physician. In addition, it would create a board of nurses and physicians to provide opinions on such new duties as would arise from time to time.

ISMS will attempt to dissuade the Illinois Department of Public Health from introducing a Radiation Users Certification bill which would create a Radiologic Technology Board of Examiners and establish criteria and minimum standards for accreditation of schools for the training of radiation users and certification of radiation users. If IDPH insists upon introducing the bill, ISMS will seek a series of amendments.

ISMS also will oppose a proposed Comprehensive Health Services bill if reintroduced in the current legislative session. The bill authorizes counties to collect funds for delivery of comprehensive health care.

In a related action, the Board agreed to support a proposed amendment to the Ambulatory Surgical Treatment Center Act that would allow podiatrists to work in surgicenters under the supervision of an appropriate member of the medical staff. Efforts to amend the Hospital Licensing Requirements to provide full medical staff membership to podiatrists, however, will be opposed.

ISMS will support an amendment to the Illinois Insurance Code requiring health insurance policies to include coverage for infants born to both married and unmarried mothers. The Board reaffirmed its position on optional inclusion of mental health coverage in all health insurance policies written in Illinois, as well as endorsing equal coverage for psychiatric illness as for any other illness under governmental health insurance programs. The Governmental Affairs Council was directed to make the latter position known to Illinois' Congressional Delegation.

Resolutions Endorsed

The Board endorsed for introduction at the 1975 House of Delegates resolutions which would:

1. Direct the ISMS Governmental Affairs Council to seek remedial legislation at the state level and AMA to undertake similar activity nationally to have the pharmaceutical package insert identified only as a guide rather than an absolute standard limiting the practice of medicine.
2. Provide a description of psychosurgery so that lay persons understand that it is an operation on the brain to modify behavior and is not therapy for a definable disease state, a form of shock treatment or related in any way to "faith healing."
3. Urge ISMS and AMA to take appropriate steps toward equalization of Medicare benefits so that treatment of psychiatric illness would be reimbursed on the same basis as any other illness.
4. Request AMA to seek repeal or modification of the federal employees' health benefits program which permits non-physicians to be reimbursed for medical services.
5. Urge AMA to discourage legislation that would expand the community mental health center concept where it interferes with a patient's free choice of physician in a pluralistic health care delivery system.

(Continued on page 294)

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylete HCl or etropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidese inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl end atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible et high dosage. Do not exceed recommended dosages. Administer with ceution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, ebdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, come, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and parelytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teespoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage edjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

SEARLE **Searle & Co.**
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Address medical inquiries to:
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454 R

Obituaries

Bancroft, Burton, Chicago, died Jan. 26, at the age of 74. Dr. Burton graduated from the University of Illinois in 1926.

****Clark, Paul,** Marseilles, died Jan. 12 at the age of 77. He graduated from Valparaiso in 1921.

****Clement, Charles,** died Jan. 9, at the age of 69. Dr. Clement graduated from the University of Illinois in 1906.

Elliot, Frank, Glencoe, died Nov. 2, at the age of 61. Dr. Elliot graduated from Northwestern in 1940.

Fishbein, Herbert, Michigan, died Sept. 23, at the age of 54. He graduated from Chicago Medical School in 1951.

***Hedges, Charles,** Oak Lawn, died Dec. 18 at the age of 37. Dr. Hedges graduated from Madras in 1962.

***Herman, William,** Calif., died Jan. 22, at the age of 71. Dr. Herman graduated from Chicago Medical School in 1934.

Jensen, J.M.L., Milwaukee, died in January at the age of 68. Dr. Jensen was on the staff at Presbyterian—St. Lukes and was chief surgeon with the Chicago Rock Island and Pacific Railroad Co.

Johnson, James, Minneapolis, died Sept. 24 at the age of 91. Dr. Johnson graduated from Northwestern in 1910.

Kales, John, Morris, died Sept. 28, at the age of 90. Dr. Kales graduated from the Chicago College of Medicine & Surgery in 1910.

Krieger, Sherburne, Los Angeles, died Sept. 23, at the age of 68. Dr. Krieger graduated from the University of Illinois in 1936.

Pitzaferro, John, Oak Brook, died Sept. 2, at the age of 72. Dr. Pitazaferro graduated from the Chicago Medical School in 1936.

***Ryan, Harry,** Centralia, died Jan. 30, at the age of 71. He graduated from the University of Illinois in 1933.

Straus, Elizabeth, Chicago, died Oct. 18, at the age of 74. Dr. Straus graduated from Rush Medical College in 1929.

Strobel, George, Wheeling, died Sept. 28, at the age of 74. Dr. Strobel graduated from the Rush Medical College in 1933.

***Thrift, Chester,** Oak Park, died Jan. 18, at the age of 67. He graduated from Rush Medical College in 1934.

Victor, Donald, Phoenix, died Sept. 24 at the age of 61. He graduated from the University of Illinois in 1947.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

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Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

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Clinics for Crippled Children Listed for April

Twenty-nine clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical social and nursing services. There will be six special clinics for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

April 1—Quincy, St. Mary's Hospital
April 3—Sterling, Sterling Community Hospital
April 3—Effingham, St. Anthony Memorial Hospital
April 3—Lake County Cardiac, Victory Memorial Hospital
April 8—E. St. Louis, Christian Welfare Hospital
April 8—Peoria, St. Francis Children's Hospital
April 8—Rock Island, Moline Public Hospital
April 9—Metropolis, Massac Memorial Hospital
April 9—Champaign-Urbana, McKinley Hospital
April 9—Hinsdale, Hinsdale Sanitarium
April 10—Cairo, Public Health Department
April 10—Springfield, St. John's Hospital
April 10—Kankakee, St. Mary's Hospital
April 11—Chicago Heights Cardiac, St. James Hospital
April 14—Peoria Cardiac, St. Francis Children's Hospital
April 16—Chicago Heights, St. James Hospital
April 17—Rockford, Rockford Memorial Hospital
April 17—Bloomington, Mennonite Hospital
April 17—Elmhurst Cardiac, Memorial Hospital of DuPage County
April 22—Peoria, St. Francis Children's Hospital
April 23—Centralia, St. Mary's Hospital
April 23—Springfield Pediatric-Neurology, Diocesan Center
April 23—Aurora, St. Joseph Mercy Hospital
April 24—Litchfield, St. Francis Hospital
April 25—Chicago Heights Cardiac, St. James Hospital
April 25—Evanston, St. Francis Hospital
April 28—Peoria Cardiac, St. Francis Children's Hospital
April 29—Mt. Vernon, Good Samaritan Hospital
April 29—Belleville, St. Elizabeth's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital—School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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Editorials



Medical Care Beset By Meddlers

At this writing, police are investigating the murders of two pharmacists whose drug stores catered to a lucrative welfare trade. A highly-paid doctor specializing in treating welfare recipients is a prime suspect. It is conjectured the two murder victims were members of a medical syndicate of doctors and drug store owners who apparently banded together to loot the Medicaid program by providing expensive and unnecessary drugs and other medical services at the State's expense.

I don't know what the outcome will be, but it should serve as a warning to legislators interested in federal and state welfare. Considering the amount of money involved, we could have a situation that might make Al Capone and his gang look like pikers.

We now find ourselves in a situation where more and more investigators and millions of additional dollars will be needed to police the health care program. It's the same old story: An attempt to help a minority usually leads to penny wise, pound foolish legislation that costs more to administer than to provide the actual benefits. You can bet that the poor will always be with us, and we will always have those who exploit the system. Unfortunately, liberals and do-gooders gloss over these issues.

It is too bad that the public is not made aware of the cost, waste, and red tape of Veterans Administration hospitals, the FDA, and military medicine.

The Federal government, including H.E.W., has deplored the incredible escalation of medical care costs. National health expenditures, at a 1974 level of $105 billion, will quickly soar to $120 billion this year. When money flows like water, it is not difficult to lose track of a billion or two. And we don't have socialized medicine!

For those who want a taste of government medicine, find out what it costs to care for a patient in a county or state hospital. You may not realize that an outpatient visit to one of our Board of Health clinics now costs the taxpayer $35.00. I'm not being critical, just factual.

Our government's answer to all of this is monitoring physicians and hospitals. This usually costs more than the monies saved. While computers are said to improve efficiency, no one mentions their cost of administration, coding, taping, and computer time. Yet a computer is no better than the people who *feed* it the information. The silly meddling that results not only robs us of the privacy and confidentiality of patient-physician relationships, but it intrudes on the whole practice of medicine.

Very little is said about the quality of health care. Instead, the computer produces reams of information on length of hospital stay, present medications, patient disabilities and diseases, along with the most intimate details of our patients' lives.

Hosptials and physicians are a target for discriminatory wage and price freezes, but the freeze does not spill over into the expenses involved in running an office.

True, medical care costs are cloaked in rhetoric, but in this case, talk is not cheap.

T. R. Van Dellen, M.D.
Editor

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Ford	Edson Etherton	Somchai Supawanich
Franklin	John P. Pope	James Durham
Fulton	J. L. Gibbs	R. H. Maguire, Jr.
Gallatin	John E. Doyle	
Greene	James C. Reid	Jose Parcon
Hancock	Chas Eddingfield	James E. Coeur
Henderson	Silvino C. Lindo	
Henry-Stark	James C. Parsons	William D. Larson
Iroquois	Kent Swedlund	James Dailey
Jackson	Paul P. Lorenz	Eli L. Borkon
Jasper		
Jefferson-Hamilton	Antonio Boba	James R. Heersma
Jersey-Calhoun	Lawrence B. Plummer	Bernard M. Baalman
Jo Daviess	William Gillies	
Kane (4)	Wayne B. Leimbach	Peter J. Starrett
	A. Beaumont Johnson	William T. Sheehy
	Gerald J. Liesen	A. Gail Baxter
	George J. Shimkus	Joseph G. Young
Kankakee	James Geist	Donald Parkhurst
Kendall	Walter H. Brill	Joseph L. Daw
Knox	H. L. Fleisher	Jerry Ramunis
Lake (4)	John Ring	Hugh C. Falls
	David Helberg	Richard Hawkins
	Eugene Pitts	Albino Bismonte
	Earl Klaren	Homer Goldstein
LaSalle	E. J. Fesco	Richard Schmidt
Lawrence	Robert C. Kirkwood	Gilbert Miller
Lee	Donald W. Edwards	Howard Edwards, Jr.
Livingston	Karl Deterding	Thomas Minogue
Logan	Glen E.Tomlinson	James Borgerson
Macon (2)	A. J. Kiessel	Robert D. Miller
	C. L. Sandburg	M. J. Schrodt
Macoupin	R. G. England	R. H. Rutherford
Madison (2)	E. K. DuVivier	Edward Ragsdale
	George T. Wilkins	Robert F. Hamilton
Marion	W. P. Plassman	L. P. Basch
Mason	Jack Means	Dario Landazuri
Massac		
McDonough	John Goncher	Samuel Gines
McHenry	August Rossetti	Ted Rolander
McLean	Loren Boon	Robert Reardon
Menard	Robert J. Schaefer	
Mercer	R. N. Svendsen	
Monroe	Russell Jost	Ingeborg. M. Kremer
Montgomery	Lee L. Johnson	
Morgan-Scott	E. C. Bone	Frank B. Norbury
Moultrie	Dean E. McLaughlin	E. J. Boros
Ogle	Don E. Hinderliter	Vincenzo L. Traina
Peoria (3)	G. W. Giebelhausen	Frederick J. Heinzen
	Ernest F. Adams	Carl F. Neuhoff
	Rex O. McMorris	Thomas W. Clark
Perry	C. E. Cawvey	James B. Stotlar
Piatt	George G. Green	Marion D. Kinzie
Pike	Myer Shulman	James E. Goodman
Pulaski	A. L. Robinson	
Randolph	O. W. Pflasterer	J. M. Whittenberg
Richland	C. A. DeKovessey	Lawrence J. Knox
Rock Island (2)	Theodore Grevas	Donald Tomlin
	W. J. Dougherty	Richard Arnell
St. Clair (3)	John S. Hipskind	Charles R. Frazer, Jr.
	Julian W. Buser	Donald Jerome
	H. Frank Holman	Thomas P. Meirink
Saline-Pope-Hardin	Alex. Z. Goldstein	Elliott D. Partridge
Sangamon (3)	Edward G. Ference	Ross Schlich
	Robert P. Johnson	Lee Winkler
	Paul F. Mahon	Stuart A. Yaffe
Schuyler	Henry C. Zingher	Robert E. Cox
Shelby	Sompong Trakarnpan	R. K. Dutta
Stephenson	E. L. Vickery	J. S. Berry
Tazewell	Albert J. Martens	Theofan R. Trifonoff
Union	Robert Rader	William Whiting
Vermilion	A. M. Taylor	M. C. Spencer
Wabash	T. R. Young	
Warren	Kenneth Ambrose	James W. Marshall
Washington	J. L. Beguelin	C. W. Longwell
Wayne	Charles J. Jannings	Edward Talaga
White	William Courtinage	Phillip Boren
Whiteside	John L. Hubbard	Clarence J. Mueller
Will-Grundy (3)	Robert J. Becker	Michael S. Greenwald
	Guy Pandola	Raymond R. Clemens
	Merle L. Otto	John E. Roth, Jr.
Williamson	Herbert V. Fine	W. R. Malone
Winnebago (4)	Robert H. Behmer	Harry W. Darland
	E. T. Leonard	R. Glenn Smith
	F. H. Riordan	Richard G. Wilson
	P. John Seward	John T. English
Woodford	H. W. Riggert	H. Thomas Barrett
Student Amer. Medical Association	Jeff Waitzman	William Yasnoff

CHICAGO MEDICAL SOCIETY

Delegates	*Alternate Delegates*
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Joseph B. Moles	Martin W. Green
Roland Kowal	Arthur G. Lawrence
Allison L. Burdick, Sr.	Gustav A. Hemwall
Everett E. Nicholas	Richard H. Blankshain
John W. Tope	Harold M. Kass
John S. Hyde	Allison L. Burdick, Jr.
Charles J. Weigel	Robert C. Muehrcke
William F. Ashley	Arthur R. Fischer
C. Otis Smith	Meredith B. Murray
Calumet Branch	
L. M. Lorance	John C. Juhasz
Hernan M. Reyes	Joseph L. Koczur
Douglas Park Branch	
Charles Mrazek	Frank J. Jirka, Jr.
Raymond W. Nemecek	Miles Cermak
J. F. Neskodny	Colman J. O'Neill
Frank Yanez	Loren B. Horton
Edward A. Razim	Robert H. MacNerland
	Eldis Christensen
Englewood Branch	
Edward J. Krol	John Krolikowski
Frank C. Kwinn	William Nainis
Frank J. Saletta	John E. Meyer
Stanley Budrys	Martin Shobris
North Suburban Branch	
David W. Cromer	Daniel J. Murphy
C. Malcolm Rice, Jr.	Thomas Gail Soper
John L. Savage	John M. Bailey
James W. Ford	Thomas J. Stafford
Leon Ampel	James R. Dillon
Richard Stalzer	Charles Z. Weingarten
James C. O'Brien	Myles P. Cunningham
John W. O'Donnell	Harley M. Sigmond
Joseph F. Hinkamp	Jerome T. Paul
	Ronald J. Ciskoski
Irving Park Suburban Branch	
George C. Turner	Alfred J. Clementi
George L. Lagorio	Philip H. Heller
Vincent C. Sarley	Peter Pleotis
Herman Wing	Theodore Johnson
Fred A. Tworoger	Earl Suckow
Lawrence L. Hirsch	Ishoona Beblis
Martin P. Meisenheimer III	Edward Burke
Allen C. Hrejsa	Augustin De La Mata
Earl N. Solon	Raymond S. Rowlette
	Jeremias Pruc
Jackson Park Branch	
Mathew W. Kobak	Lester D. Odell
Murry M. Paull	Myron M. Hipskind
Helen Cook Newman	Nerissa P. Singh
	T. W. Lester

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Norman M. C. Olsen	Danforth O. Chamberlain
Burton J. Soboroff	H. Kenneth Scatliff
Clarence A. Norberg	Samuel T. Gerber
David T. Petty	William B. Stromberg
Frank E. Nagel	Jack D. Clemis
George C. Markoutsas	Charles A. Mudd
Cyril C. Wiggishoff	Noel Nequin
Herschel Browns	Jesse E. Waller
William O. Ackley	George Greenfield
Willis G. Diffenbaugh	Jerome J. Frankel
Rocco V. Lobraico, Jr.	Robert C. Hamilton
Frank Hussey, Jr.	Lloyd Callaway
Joseph H. Skom	Maurice Colbert
North Side Branch	
Joseph C. Sherrick	Peter Wolkonsky
Roland R. Cross	Daniel Ruge
Samuel L. Andelman	George S. Farah
William A. Hutchison	Bernard T. Peele
C. Larkin Flanagan	V. Raymond Silins
Vincent C. Freda	Richard A. Perritt
Jack Williams	Benjamin F. Lounsbury
Erwin M. Patlak	B. H. Gerald Rogers
Clifton L. Reeder	Joseph Schifano
James P. Fitzgibbons	Randolph W. Seed
Carl F. Palumbo	Anton M. Pantone
Northwest Branch	
M. A. Rydelski	Alfonso Diaz
E. J. Kotanyi	N. J. Kupferberg
Gonzalo Ruiz	John Szewczyk
Finley Brown	I. P. Lombardo
South Chicago Branch	
Morris T. Friedell	Jere E. Freidheim
Arne E. Schairer	Maynard I. Shapiro
Vincent A. Costanzo	Anthony Guzauskas
South Side Branch	
Alfred D. Klinger	Aldo F. Pedroso
Robert R. Mustell	Vernon R. DeYoung
Otto J. Keller	
Kermit T. Mehlinger	
Southern Cook County	
Aaron B. Gerber	William J. Marshall
Conrad J. Urban	Raymond Romanus
Roman I. Filipowicz	John Nayden
Harold Yatvin	Alex Kaz
Harold L. Jensen	Joseph Gorecki
Stock Yards Branch	
Edwin J. Lukaszewski	Frank J. Nowak
West Side Branch	
William J. Tansey	Jacob Ungar
Anna A. Marcus	Henry B. Okner
J. Robert Thompson	Louis S. Varzino

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Howard C. Burkhead
David S. Fox
Henrietta Herbolsheimer
Alfred J. Faber
Lawrence L. Hirsch

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1975

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Alexander Members: 7-Dist. 10	Lewis Ent 309 8th St., Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
Bond Members: 7-Dist. 7	James R. Goggin 207 N. 2nd St., Greenville, 62246	M. Kenneth Kaufmann 105 E. College, Greenville 62246
Boone Members: 14-Dist. 1	Adrian Schreiber Caledonia 61011	Earl S. Davis 119 So. State, Belvidere 61008
Bureau Members: 30-Dist. 2	Kent Monroe 207 E. St. Paul, Spring Valley 61362	K. Dexter Nelson 101 Park Ave., Princeton 61356
Carroll Members: 9-Dist. 1	Eliseo M. Colli 102 E. Washington, Mt. Carroll 61053	Basilios Lambos Broad St., Lanark 61046
Cass-Brown Members: 5-Dist. 6	R. A. Spencer 115 W. 4th St., Beardstown 62618	B. A. DeSulis 115 W. 4th St., Beardstown 62618
Champaign Members: 194-Dist. 8 Larry Booth, Ex. Sec. 407 S. 4th St. Champaign 61820	Stanley Smith Carle Clinic, Urbana 61801	H. Ewing Wachter 2108 W. Springfield, Champaign 61820
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Clay Members: 8-Dist. 7	A. Paul Naney Flora Clinic, Flora 62839	Donald L. Bunnell Flora Clinic, Flora 62839
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Crawford Members: 14-Dist. 8	M. D. Miodus Oblong Clinic, Oblong 62449	W. B. Schmidt 408 S. Cross, Robinson 62454
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De Witt Members: 11-Dist. 5	John W. Veirs 219 E. Main St., Clinton 61727	Charles A. Ramey 215 E. Main St., Clinton 61727
Douglas Members: 10-Dist. 8	R. N. Arrol 126 S. Locust, Arcola 61910	Max Johnson Newman 61942
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Edwards Members: 2-Dist. 9	Paul S. Neirenberg 7 W. Main St., Albion 62806	Andrew Krajec Box 336, West Salem 62476
Effingham Members: 22-Dist. 7	L. Beis 702 W. Kentucky, Effingham 62401	John A. Chalstrom 416 W. Virginia, Effingham 62401
Fayette Members: 7-Dist. 7	D. H. Rames 1029 N. 8th, Vandalia 62471	Hans Rollinger 1003 N. 8th St., Vandalia 62471
Ford Members: 11-Dist. 11	William A. Garrett Sibley 61773	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 23-Dist. 9	Loren L. Love 6 Hillcrest Dr., Christopher 62822	D. P. Richerson P.O. Box 99, Christopher 62822
Fulton Members: 29-Dist. 4	Robert W. Ridley 175 S. Main, Canton 61520	Marvin E. Schmidt 210 W. Walnut, Canton 61520
Gallatin Members: 1-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 7-Dist. 6	Ludwig Dech 132 W. Lorton, Roodhouse 62082	James C. Reid Fillager Mem. Clinic, Greenfield 62044
Hancock Members: 9-Dist. 4	Werner Schoenherr Bowen 62316	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 1-Dist. 4		Silvino Lindo, Jr. Biggsville 61448
Henry-Stark Members: 31-Dist. 4	Lawrence N. Wathier 119½ S. State, Geneseo 61254	David E. Stearns 513 Elliott, Kewanee 61443
Iroquois Members: 18-Dist. 11	S. D. Roeder 845 S. 4th St., Watseka 60970	Harry Barnett P.O. Box 128, Ashkum 60911
Jackson Members: 67-Dist. 10	Masood Akhtar 18 N. 11th St., Murphysboro 62966	Paul Lorenz P.O. Box 2347, Carbondale 62901
Jasper Members: 2-Dist. 8	Don L. Hartrich 1211 W. Jourdan, Newton 62448	Monico Low 609 S. Van Buren, Newton 62448
Jefferson-Hamilton Members: 32-Dist. 9	Gerald E. Fox 1 Doctors Park Rd., Mt. Vernon 62864	Antonio Boba P.O. Box 643, Mt. Vernon 62864
Jersey-Calhoun Members: 9-Dist. 6	Bernard Baalman Medical Center, Hardin 62047	Clyde Wieland Maple Summit Rd., Jerseyville 62052
Jo Daviess Members: 7-Dist. 1	Wilbur E. Johnson Galena 61036	Lyle A. Rachuy 323 N. Main St., Stockton 61085
Kane Members: 283-Dist. 1 Michael Wild, Ex. Dir. 11 So. 2nd St. Geneva, Ill. 60134	Emanuel M. Herzon 860 Summit St., Elgin 60120	David J. Clark 1870 W. Galena Blvd., Aurora 60506
Kankakee Members: 101-Dist. 11	Preston W. Sawyer 70 Meadowview Center, Kankakee 60901	A. A. Palow 555 So. Schuyler, Kankakee 60901
Kendall Members: 7-Dist. 11	Victor Smith Newark 60541	John P. Cullinan Oswego 60543
Knox Members: 63-Dist. 4	F. P. Weyrens 3315 N. Seminary, Galesburg 61401	R. B. Howell 1708 N. Prairie, Galesburg 61401
Lake Members: 287-Dist. 1 Julia Schulz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	David Helberg 1702 Washington, Waukegan 60085	Joseph L. Burke 2504 Washington, Waukegan 60085

County	President	Secretary
LaSalle Members: 102-Dist. 2	William E. Erkonen 308 E. Kent, Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 10-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence City Mem. Hosp. Lawrenceville, Ill. 62439	Gilbert Miller North Main St., Bridgeport 62417	Alexander Po R.R. #2, Lawrenceville 62439
Lee Members: 21-Dist. 2	Michael Hong 403 E. 1st St., Dixon 61021	Samuel Adler N. Ottawa Dr., Dixon 61021
Livingston Members: 28-Dist. 2	Leslie Lowenthal 420 N. Plum, Pontiac 61764	Karl T. Deterding 612 E. Water St., Pontiac 61764
Logan Members: 21-Dist. 5	Glen Tomlinson #4 Doctor's Park, Lincoln 62656	Robert Brown Perry 311 8th St., Lincoln 62656
Macon Members: 149-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur, Ill. 62521	Otto Brosius 2300 N. Edward, Decatur 62521	William C. Simon 1807 N. Edward St., Decatur 62521
Macoupin Members: 20-Dist. 6	Robert H. Rutherford 224 E. Main St., Carlinville 62626	Robert England 224 E. Main, Carlinville 62626
Madison Members: 152-Dist. 6	Nancy Voege 307 Henry, Alton 62002	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 39-Dist. 7	S. E. Rubio Box 609, Salem 62881	W. P. Plassman Box 552, Centralia 62801
Mason Members: 6-Dist. 5	Dario Landazuri 125 N. Orange St., Havana 62644	Henry W. Maxfield Mason City 62664
Massac Members: 4-Dist. 9	James L. Bremer 805 Market, Metropolis 62960	
McDonough Members: 27-Dist. 4	Joseph L. Symmonds 301 E. Jefferson, Macomb 61455	Stephan L. Roth Box 258, Colchester 62326
McHenry Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Ave. Woodstock, Ill. 60098	William R. Larsen 13707 W. Jackson, Woodstock 60098	Daniel E. Horan 527 W. South St., Woodstock 60098
McLean Members: 95-Dist. 5 Mrs. Cathy Sengpiel Exec. Sec. 401 W. Virginia Normal, Ill. 61761	Robert Killough 401 W. Virginia, Normal 61761	Douglas R. Bey 401 W. Virginia, Normal 61761
Menard Members: 1-Dist. 5	Robert J. Schafer 116 N. 5th, Petersburg 62675	Robert J. Schafer 116 N. 5th St., Petersburg 62675
Mercer Members: 4-Dist. 4	R. N. Svendsen 209 S. College, Aledo 61231	Monty P. McClellan 309 NW 2nd, Aledo 61231
Monroe Members: 8-Dist. 10	I. Kremer 854 W. Bottom, Columbia 62236	Edelberto Maglasang 109 W. Legon, Columbia 62236
Montgomery Members: 20-Dist. 5	L. George Allen 400 N. Monroe, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056
Morgan-Scott Members: 38-Dist. 6	A. M. Paisley 209 W. State, Jacksonville 62650	R. H. Kooiker 1600 W. Walnut, Jacksonville 62650
Moultrie Members: 5-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle Members: 17-Dist. 1	L. T. Koritz 324 Lincoln Hgwy., Rochelle 61068	Russell Zack 915 Caron Rd., Rochelle 61068

County	President	Secretary
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Perry Members: 18-Dist. 10	W. M. Thornburg Medical Group Bldg., DuQuoin 62832	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 6-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 8-Dist. 6	Warren C. Barrow 321 W. Washington, Pittsfield 62363	B. J. Rodriguez 868 Mortimer, Barry 62312
Pulaski Members: 1-Dist. 10	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 20-Dist. 10	L. C. Fiene W. Belmont St., Sparta 62286	C. S. Schlageter 818 E. Broadway, Sparta 62286
Richland Members: 27-Dist. 8	I. Keith Edwards 1200 N. East St., Olney 62450	Lawrence J. Knox 1200 N. East St., Olney 62450
Rock Island Members: 166-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	George Burke 2701 17th St., Rock Island 61201	Earl H. Clark 2701 17th St., Rock Island 61201
St. Clair Members: 220-Dist. 10 Ed Belz, Exec. Sec. 4825 W. Main Belleville, Ill. 62223	Mays Maxwell P.O. Box 1250, E. St. Louis 62222	Donald Jerome 301 W. Lincoln, Belleville 62221
Saline-Pope-Hardin Members: 29-Dist. 9	Gary D. Cody 1201 Pine St., Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
Sangamon Members: 242-Dist. 5 L. R. Brosi, Ex. Dir. 2100 Lindsay Rd. Springfield, Ill. 62704	Gerald T. Riordan 613 N. 7th St., Springfield 62702	Robert L. Prentice 701 N. Walnut, Springfield 62702
Schuyler Members: 3-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 7-Dist. 7	H. H. Pettry 407 W. Main St., Shelbyville 62565	Otto G. Kauder P.O. Box 395, Shelbyville 62565
Stephenson Members: 51-Dist. 1	Robert L. Rockey 3103 W. Stephenson, Freeport 61032	Roger Jinkins 1262 W. Stephenson, Freeport 61032
Tazewell Members: 47-Dist. 5 David W. Meister, Jr., Exec. Sec. 427 1st National Bk. Bldg. Peoria, Ill. 61602	John B. Sombeck 427 1st National Bk. Bldg., Peoria	Robert M. Wright 427 1st National Bk. Bldg., Peoria
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Vermilion Members: 94-Dist. 8	W. F. Hensold 7 N. Virginia Ave., Danville 61832	L. W. Tanner 7 N. Virginia, Danville 61832
Wabash Members: 7-Dist. 9	Roger Fuller 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 11-Dist. 4	W. Roller 309 S. Main, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462

County	President	Secretary
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Wayne Members: 7-Dist. 9	C. J. Jannings, III 301 N.W. 11th St., Fairfield 62837	S. W. Konarski 101 E. Center St., Fairfield 62837
White Members: 8-Dist. 9	William Courtnage West Main St., Carmi 62821	Morris McCall So. Plum St., Carmi 62821
Whiteside Members: 43-Dist. 2	William G. Manalo 911 Albany, Erie 61250	Timothy B. Sullivan, Jr. 1716 Locust, Sterling 61081
Will-Grundy Members: 199-Dist. 11 Patricia Love, Mgr. 58 N. Chicago St. Joliet, Ill. 60431	Albert W. Ray 58 N. Chicago St., Joliet 60431	Stephen E. Copp 58 N. Chicago, Joliet 60431
Williamson Members: 30-Dist. 9	George Murphy Marion Mem. Hosp., Marion 62959	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 315-Dist. 1 Mrs. Johanna Lund Exec. Adm. 310 N. Wyman St. Rockford, Ill. 61101	Miles J. Gullickson 310 N. Wyman St., Rockford 61101	John English 310 N. Wyman St., Rockford 61101
Woodford Members: 7-Dist. 2	H. W. Riggert Metamora 61548	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society

Johnson
Marshall
Putnam

Joint County Societies

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

NOTE TO THE MEMBERSHIP

This year the Delegate's Handbook is published in abbreviated form in the *Illinois Medical Journal*. The time of the meeting, dates of meetings of the Board of Trustees, and the need to allow greater latitude in developing reports has made necessary an attempt to provide reports in a better format.

All items which were available at publication deadline are included in this issue. Reports were deadlined for late February and will be reproduced and distributed to all county medical society officers and delegates in early March. Any member also desiring a packet of the materials may obtain one by requesting same of ISMS Headquarters. Delegates and alternates are reminded to bring the packet of materials with them to the annual Meeting, as there are not sufficient quantities to give each person another.

DAMN!!!

That's exactly what you'll be saying——

if you don't get involved!

- **Fee Schedules for Physicians**
- **Rate Review Legislation**
- **National Health Insurance**
- **Chiropractors doing School Physicals**

These and many other issues of vital medical significance will soon be considered by the U.S. Congress and the Illinois State Legislature.

Question: **What can the physician do?**

Answer: **He or she can become informed and involved politically.**

Question: **But, I'm too busy, and I don't know anything about legislation and politics. What should I do?**

Answer: **Plan now to attend the . . .**

IMPAC-AMPAC WORKSHOP

Thursday, April 3, 1975

McCormick Place
Chicago, Illinois

1:00 p.m. Room 20-8W	Complimentary luncheon featuring a noted national speaker
2:00 p.m. Room 20-2W	Vital workshop on physician involvement

Program Summary By Days

(Preliminary)

Tuesday
April 1, 1975

9:00 a.m.	Medical Direction in Long Term Care Facility Meeting	Jane Addams Room McCormick Place
12:00 noon	Luncheon for above	Dr. Lawless Room McCormick Place
1:30 p.m.	IFMC Board Meeting	McCormick Inn
6:00 p.m.	ISMS Board Meeting	McCormick Inn

Wednesday
April 2, 1975

8:00 a.m.	Delegate Registration	
9:00 a.m.	Instruction and Scientific Programs	
9:00 a.m.	Medical Direction in Long Term Care Facility Meeting	Jane Addams Room McCormick Place
10:00 a.m.	ISMS District Caucuses	McCormick Inn
2:00 p.m.	House of Delegates Registration	McCormick Inn
3:00 p.m.	House of Delegates	McCormick Inn
5:30 p.m.	Delegates Buffet	McCormick Inn
7:00 p.m.	Reference Committees Open Forum Constitution & Bylaws	McCormick Inn

A. Officers & Administration

B. Economics, Peer Review, Social & Medical Services

C. Education & Manpower

D. Environmental, Community, & Mental Health

E. Finances, Budgets & Publications

F. Governmental Affairs & Medical Legal

G. Public Relations, Membership & Miscellaneous Business

Thursday
April 3, 1975

8:00 a.m.	ISMS Board Breakfast Mtg.	McCormick Inn
8:00 a.m.	Registration Opens	
9:00 a.m.	Instructional and Scientific Programs	
9:00 a.m.	Malpractice and the Doctor Defendent	Olive Harvey Room McCormick Place
9:00 a.m.	Management and Treatment of Alcoholism	John Evers Theatre McCormick Place

1:00 p.m.	IMPAC-AMPAC Luncheon	Room 20-8W McCormick Place
2:00 p.m.	IMPAC-AMPAC Workshop	Room 20-2W McCormick Place
4:00 p.m.	IMPAC Annual Meeting	
6:00 p.m.	ISMS President's Dinner/Dance	McCormick Inn

Friday
April 4, 1975

7:30 a.m.	Public Affairs Breakfast	McCormick Inn
8:00 a.m.	Registration Opens	
9:00 a.m.	Instructional and Scientific Programs	
12:00 noon	50 Year Club Luncheon Meeting	McCormick Inn
2:00 p.m.	House of Delegates	McCormick Inn
6:00 p.m.	ISMS Board Dinner	McCormick Inn
6:00 p.m.	U. of Ill. Alumni Dinner	McCormick Inn

Saturday
April 5, 1975

9:00 a.m.	House of Delegates	McCormick Inn

Woman's Auxiliary Convention Program

Tuesday, April 1—4:30 p.m.—Pre-convention Board meeting and dinner.

Wednesday, April 2—8:30 a.m.—Members-at-large, Caucus coffee
- 9-9:30 —By-Laws, "Buzzin"
- 9:30 —1st Delegate Session
 - a. Keynote speaker—Mrs. Howard Liljestrand.
 - b. Report of the nominating committee
 - c. Election of Officers
 - d. Presentation of Amendments to the by-laws
 - e. Presentation of Awards for membership, AMA-ERF, and Health Careers.
- 12:30 —Presidents luncheon—Fashion show by Saks Fifth Ave.
- 3:00 —2nd Delegates Session
- Evening —Reception for the State President—Mrs. Thomas Glatter.

Thursday, April 3—9:30 a.m.—County Day
- 12:30 p.m.—Installation luncheon
 Waa-Mu performers from Northwestern University
- 3:00 Leadership workshop

Friday, April 4—7:30 a.m.—Public Affairs Breakfast—Michael Howlett—speaker
- 9:30 —3rd Delegates Session
 - a. Adoption of the Budget
 - b. Election of the Nominating Committee
 - c. Elections of the Delegates to the National Convention
- 11:00 —Post Convention Board Meeting

Agenda
1975 House of Delegates

Andrew J. Brislen, *Speaker*

James A. McDonald, *Vice-Speaker*

FIRST SESSION
3:00 P.M. Wednesday, April 2, 1975
McCormick Inn Ballroom
Chicago

1. Call to order by the *Speaker* Andrew J. Brislen, M.D.
2. Invocation
3. Report of Credentials Committee E. K. DuVivier, M.D. and Henrietta Herbolsheimer, M.D. *Co-Chairmen*
4. Report of Committe on Rules and Order of Business A. J. Kiessel, M.D. *Chairman*
5. Approval of the minutes of the April, 1974, meeting
6. Memorial service for deceased members since April, 1974, conducted by Jacob E. Reisch, M.D., *Secretary-Treasurer*
7. Reports of Special Guests
 (a) President, Womans' Auxiliary to the Illinois State Medical Society
 Mrs. Thomas Glatter
 (b) President, American Association of Medical Assitants, Illinois Society
 Mrs. Walter H. Johnson
8. Introduction of special guests
9. Presentation of AMA-ERF check to Illinois medical schools
10. Presentation of Hamilton Teaching Award to John Sheehan, M.D.
11. The President's Address
 Fredric D. Lake, M.D.
12. IMPAC Report
 Fred A. Tworoger, M.D., *Chairman*
13. Report of Executive Administrator
 Roger N. White
14. Introduction of AMA Delegates and Alternate Delegates
 Edward A. Piszczek, M.D., *Chairman of Delegation*
15. Presentation of 1974 Medical Journalism Awards
16. Remarks of Speaker and Announcement of Changes in Reference Committees
17. Resolutions and Supplementary Reports
 (a) Late Resolutions
 (b) Supplementary Reports
18. New Business — Announcements
 (a) Delegates Buffet — 5:30 P.M.
 (b) Reference Committees — 7:00 P.M.
19. Recess until 2:00 P.M. Friday, April 4, 1975

SECOND SESSION
2:00 P.M. Friday, April 4, 1975
McCormick Inn Ballroom
Chicago

1. Call to order by the Speaker
2. Invocation
3. Report of Credentials Committee
4. Report of Committee on Rules and Order of Business
5. Announcements and Introduction of Guests
 Amendments to Constitution and Bylaws
 Everett R. Nicholas, M.D. *Chairman*
 A. (Reports of Officers & Administration)
 Allen C. Hrejsa, M.D., *Chairman*
 B. (Economics, Peer Review, Social and Medical Services)
 William A. Hutchison, M.D., *Chairman*
 C. (Education and Manpower)
 Jack Gibbs, M.D. *Chairman*
 D. (Environment, Community and Mental Health)
 Karl Deterding, M.D., *Chairman*
 E. (Finances, Budgets & Publications)
 Guy Pandola, M.D., *Chairman*
 F. (Governmental Affairs and Medical-Legal)
 Alfred J. Faber, M.D., *Chairman*
 G. (Public Relations, Membership and Miscellaneous Business)
 M. K. Kaufman, M.D., *Chairman*
 (i) Delegates to AMA to take office Jan. 1, 1976,
6. Reports of Reference Committees
7. Unfinished business
8. New business
9. Recess until 9:30 a.m. Saturday, April 5, 1975

THIRD SESSION

9:30 A.M. Saturday, April 5, 1975

McCormick Inn Ballroom

Chicago

1. Call to order by the Speaker
2. Invocation
3. Report of Credentials Committee
4. Report of Committee on Rules and Order of Business
5. Induction of Jerry M. Ingalls, *President-Elect,* into office of President by Fredric D. Lake
6. Address of President Ingalls
7. Announcements and introduction of special guests
8. Reports of Reference Committees
9. Elections

Report of Nominating Committee

(a) President-Elect (CMS)
(b) 1st Vice President (Downstate)
(c) 2nd Vice President (CMS)
(d) Secretary-Treasurer (Downstate)
(e) Speaker of House (Downstate)
(f) Vice Speaker (CMS)
(g) Trustees

DISTRICT	Terms Expiring
3rd	Eugene T. Hoban
3rd	Joseph Skom
3rd	Warren W. Young
6th	Mather Pfeiffenberger
9th	Warren D. Tuttle
10th	Herbert Dexheimer

(h) Delegates to AMA to take office April 5, 1975, and serve until Dec. 31, 1976 (one to be elected to fill new delegate position)

(i) Delegates to AMA to take office Jan. 1, 1976, and serve until Dec. 31, 1977

Terms Expiring:

Jack Gibbs
Theodore Grevas
Morgan M. Meyer
Edward A. Piszczek
Philip G. Thomsen
Vacancy (created by Dr. Frank Jirka's election to AMA Board of Trustees)

(l) Alternate Delegates to AMA to take office April 5, 1975, and serve until Dec. 31, 1976 (one to be elected to fill new alternate delegate position)

(k) Alternate Delegates to AMA to take office Jan. 1, 1976, and serve until Dec. 31, 1977

Terms Expiring:

Herschel Browns
Allison Burdick, Jr.
Jerry M. Ingalls
Joseph R. O'Donnell
George Shropshear
Paul W. Sunderland
Glen Tomlinson

10. Fixing of per capita dues for 1976
11. Selection of meeting place and time for next annual meeting
12. Unfinished business
13. New business
14. Adjournment, *sine die*

All members are urged to participate in the

Reference Committee Meetings

Wednesday, April 2, 1975

7:00 p.m.

Constitution & Bylaws	Room XVI
A. Officers & Administration	Room XVII
B. Economics, Peer Review, Social & Medical Services	Room VII
C. Education & Manpower	Room X-XI
D. Environmental, Community & Mental Health	Room XII
E. Finances, Budgets & Publications	Room XIV
F. Governmental Affairs & Medical-Legal	Room XIII
G. Public Relations, Membership & Miscellaneous Business	Room XV

1975 Committees of the House of Delegates

COMMITTEE ON CREDENTIALS

Edward DuVivier, *Co-Chairman,* (DS)
Henrietta Herbolsheimer,*Co-Chairman,* (CMS)

J. F. Neskodny (CMS) — William C. Perkins (DS)
Helen Newman (CMS) — John P. Pope (DS)

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

COMMITTEE ON RULES & ORDER OF BUSINESS

A. J. Kiessel, *Chairman* (DS)

James P. Campbell (DS) — Clarence A. Norberg (CMS)
Paul P. Lorenz (DS) — Vincent C. Sarley (CMS)
Charles J. Weigel (CMS)

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

TELLERS AND SERGEANTS AT ARMS

Edwin J. Lukaszewski, *Chairman* (CMS)

Walter Brill (DS) — Frank E. Nagel (CMS)
Gerald J. Liesen (DS) — Harold Yatvin (CMS)

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Standby:
Edward J. Fesco (DS)

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

Everett B. Nicholas, *Chairman* (CMS)

Loren Boon (DS) — George T. Mitchell (DS)
James P. Fitzgibbons (CMS) — Joseph C. Sherrick (CMS)

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

Standby:
Edward Ference (DS)

REFERENCE COMMITTEE A (REPORTS OF OFFICERS AND ADMINISTRATION)

Allen C. Hrejsa, *Chairman* (CMS)

Jack D. Clemis (CMS) — Alan M. Taylor (DS)
Mack Hollowell (DS) — John W. Tope (CMS)

Standby:
Kenneth Hurst (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

President
President-elect
1st Vice President
2nd Vice President
Secretary
Chairman of the Board
Trustees from the 11 districts
Trustee-at-large

Speaker of the House
Vice Speaker of the House
Chairman, AMA Delegation
Executive Administrator
President, Woman's Auxiliary

Policy Committee
President, American Association of Medical Assistants, Illinois Chapter

Advisory Committee to Woman's Auxiliary

Ethical Relations Committee

Committee on Physician Competence

Committee on Committees

House Select Committee

REFERENCE COMMITTEE B
(ECONOMICS, PEER REVIEW, SOCIAL & MEDICAL SERVICES)

William A. Hutchison, *Chairman* (CMS)

Julian W. Buser (DS) — A. Beaumont Johnson (DS)
Roland R. Cross (CMS) — M. P. Meisenheimer (CMS)

Standby:
Charles Eddenfield

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Committee on Drugs & Therapeutics
- Council on Economics & Peer Review
- Council on Social & Medical Services
- Government Health Programs Reimbursement Committee
- Health Care Finance Committee
- Director, Illinois Department of Public Aid
- Director, Illinois Division of Vocational Rehabilitation
- Hospital Relations Committee
- Comprehensive Health Planning Committee
- IFMC

REFERENCE COMMITTEE C
(EDUCATION AND MANPOWER)

Jack L. Gibbs, *Chairman* (DS)

Jere E. Freidheim (CMS) — Edward J. Krol (CMS)
H. Frank Holman (DS) — F. H. Riordan (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Council on Education and Manpower
- Illinois Council on Continuing Medical Education
- Illinois Department of Registration & Education
- Student Loan Fund

REFERENCE COMMITTEE D
(ENVIRONMENTAL, COMMUNITY & MENTAL HEALTH)

Karl Deterding, *Chairman* (DS)

Chas. A. DeKovessey (DS) — Eugene Pitts (DS)
Alfred D. Klinger (CMS) — Hernan M. Reyes (CMS)

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Council on Environmental & Community Health
- Council on Mental Health & Addiction
- Director, Illinois Department of Public Health
- Director, Illinois Department of Mental Health
- Director, Illinois Department of Children & Family Services
- Department of Corrections

REFERENCE COMMITTEE E
(FINANCES, BUDGETS AND PUBLICATIONS)

Guy Pandola, *Chairman* (DS)

Stanley Budrys (CMS) — James C. Parson (DS)
Mathew Kobak (CMS) — James E. Sutherland (DS)

Standby:
Robert H. Behmer

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Educational & Scientific Foundation
- Finance and Medical Benevolence Committee
- Publications Committee
- Treasurer
- Budgets prepared and approved by Board of Trustees

REFERENCE COMMITTEE F
(GOVERNMENTAL AFFAIRS & MEDICAL-LEGAL)

Alfred J. Faber, *Chairman* (CMS)

David Helberg (DS) — P. John Seward (DS)
Henry B. Okner (CMS) — Herman Wing (CMS)

Standby:
Henry C. Zingher

This committee shall consider and submit its recommendations to the House of Delegates upon the following reports:

- Medical-Legal Council
- Governmental Affairs Council
- Committee on Quackery
- IMPAC

REFERENCE COMMITTEE G
(PUBLIC RELATIONS, MEMBERSHIP AND MISCELLANEOUS BUSINESS)

M. K. Kaufman, *Chairman* (DS)

Herbert V. Fine (DS) — Frank Hussey, Jr. (CMS)
William B. Frymark (DS) — L. M. Lorance (CMS)

Standby:
Antonio Boba (DS)

This committee shall consider and submit its recommendations to the House of Delegates upon the reports of the following committees and upon any other matters referred by the Speaker:

- Insurance Committee
- Council on Public Relations & Membership Services
- Council on Affiliate Societies

Resolutions

Resolution 75A-1

Introduced by: Joseph L. Bordenave, M.D., for The Board of Trustees
Subject: Continued Funding for Illinois Council on Continuing Medical Education
Referred to: Reference Committee E

WHEREAS, The House of Delegates in 1971 recognized the growing need of and demand for continuing medical education by authorizing establishment of the Illinois Council on Continuing Medical Education, a unique organizational approach that unites the energies and resources of ISMS and the State's medical schools; and

WHEREAS, The House expressed its full support for the ICCME concept by alloting for the Council's use, half ($10) of the 1972, 1974 and 1975 AMA-ERF assessment, and further in 1973 voted that ISMS should "support the activities of the Illinois Council on Continuing Medical Education to the extent authorized by this House of Delegates;" and

WHEREAS, During its first two years of operational status, ICCME has provided vigorous and fruitful stimulus to the growth of CME in Illinois through a wide variety of activities, of which these deserve special mention: two state-wide congresses on CME, the unique handbook *Your Personal Learning Plan,* the monthly CME Calendar for *Illinois Medical Journal,* workshops for hospital staff and county society members, assistance to hospitals seeking CME accreditation as well as essential staff work for the Illinois CME Accreditation Program (including revision of accreditation documents in response to AMA critique); and

WHEREAS, ICCME has gained a national reputation that has brought credit to its sponsors, the Illinois State Medical Society and the State's eight medical schools, and has stimulated interest in similar joint efforts in other states; and

WHEREAS, ICCME has been steadily growing as a source of facts and ideas useful for CME planning, as well as an effective medium for the interchange of useful ideas and practices among CME planners throughout the State; and

WHEREAS, Illinois physicians, medical schools, hospitals, and other health institutions have welcomed ICCME services that do not produce income, proving the wisdom of previous House of Delegates action in providing funds for ICCME's basic operation, which in turn has made possible ICCME activities that can be self-supporting (such as workshops on CME technique); therefore, be it

RESOLVED, That half ($10) of each member's 1976 AMA-ERF contribution be allocated to the Illinois Council on Continuing Medical Education for use in activities as determined by the ICCME Board of Directors.

Resolution 75A-2

Introduced by: Charles J. Jannings, III, M.D., for the Wayne County Medical Society
Subject: Formation of Independent Union of Physicians
Referred to: Reference Committee G

WHEREAS, The physicians engaged in the practice of medicine in Wayne County face increasing economic pressure from many sources including, but not limited to, Medicaid, Medicare, National Heatlh Insurance, Wage-Price Controls, PSRO, Comprehensive Health Planning, and Re-licensure; and

WHEREAS, Organized medicine and its arms have not demonstrated the will to or assumed the responsibility to defend the economic interests of these physicians; therefore, be it

RESOLVED, That the Illinois State Medical Society encourage the immediate formation of an independent union of physicians licensed to practice medicine and surgery in all of its branches within the State of Illinois.

Resolution 75A-3

Introduced by: A. Edward Livingston, M.D., for the Committee on Constitution and Bylaws
Subject: Amendment to Bylaws Chapter I, Membership
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, Citizenship is not a requirement for physician licensure in Illinois or for membership in many county medical societies; therefore, be it

RESOLVED, That all reference to citizenship be eliminated from the ISMS bylaws by amending Chapter I as follows:

Section 1. Members. Membership shall consist of Regular members, [Provisional members,] Associate members, Emeritus members, Retired members, Service members, Distinguished members. In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

B. [Provisional Members. Provisional membership shall be avaialble to any Illinois physician who has made a declaration of intention to become a citizen of the United States, who has received a license in this State to practice medicine in all of its branches, and who—with the exception of United States citizenship—possesses all of the qualifications for membership prescribed by these Bylaws. Provisional membership shall terminate one year after the expiration of the minimum period of time which such member could have perfected his citizenship. After obtaining full citizenship and prior to the expiration of his provisional membership, such member may be, upon application to his component medical society, transferred to regular membership.]

Items in brackets to be deleted.

Resolution 75A-4

Introducted by: A Edward Livingston, M.D., for the Committee on Constitution and Bylaws
Subject: Amendments to Chapters I, II and X of the Bylaws to Clarify Dues Payment Dates
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, Various references to dues payments dates in the bylaws are confusing; therefore, be it

RESOLVED, That Chapters I, II, and X be amended as follows:

CHAPTER I. MEMBERSHIP

Section 3. Tenure and Termination

B. Termination of Membership. Any person who is under sentence of suspension, or expulsion from a component society shall not be entitled to any

rights or benefits of this society, nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Non-payment of dues by [May 1 of each year shall be grounds for] *an established final date, as hereinafter provided, shall automatically result* in termination of membership.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal*. Only Regular, [Provisional,] Associate, In-training and Student members shall be assessed annual dues. The dues shall be paid by the component society for its members prior to [May 1 of each year] *an established delinquency date as hereinafter provided.*

CHAPTER X. COUNTY SOCIETIES

Section 9. The secretary of each component society shall foward its roster of officers and members, and a list of delegates and alternate delegates to the secretary of this society no later than [120 days prior to the annual meeting] *March 1.*

Section 10. *Annual dues of members are due and payable to the component society on the first day of January of each year. Each component society shall send a second dues notice to those members with unpaid dues on February 1, advising that February 15 is the final date for payment to avoid being considered delinquent.* Any component society which fails to [pay its assessment or] make the annual report required on or before March [fifteenth] *first* shall be held as delinquent and suspended, and none of its members shall be permitted to participate in any of the business or proceedings of the society or of the House of Delegates until such requirements have been met. [A member is in good standing] Unless otherwise disqualified, *a member of ISMS is in good standing* whose dues are [paid] *received from his component society* on or before the first day of March of the current year. [Immediately after the first of March, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be dropped automatically.] *Each delinquent member shall receive from the state society a final notice of delinquency, as a result of non-payment of dues, effective on March fifteenth. Members whose dues remain unpaid shall be automatically dropped from membership in the state society and shall be notified of such termination no later than April 1.*

Thereafter, such former member must make application as a new member.

Items in brackets to be deleted.
Italic items added.

Resolution 75A-5

Introduced by: A. Edward Livingston, M.D., for the Committee on Constitution and Bylaws
Subject: Amendment to Chapter IX of the Bylaws
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, It would be more appropriate for the immediate past president of the Illinois State Medical Society to serve as chairman of the Advisory Committee to the Women's Auxiliary than for the president-elect of ISMS to head this committee; therefore, be it

RESOLVED, That Chapter IX, Section 6-H, be amended as follows:

Section 6. Board of Trustees Committees.

H. The Advisory Committee to the Woman's Auxiliary shall consist of the [president-elect] *immediate past president* as chairman, the president and the chairman of the Board of Trustees.

Brackets delete; italics add.

Resolution 75A-6

Introduced by: A. Edward Livingston, M.D., for the Committee on Constitution and Bylaws
Subject: Amendments to Chapter XI of the Bylaws
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The Board of Trustees of the Illinois State Medical Society has accepted a recommendation from its legal counsel that Chapter XI, Discipline, be revised for clarification; therefore, be it

RESOLVED, That Chapter XI be amended as follows:

CHAPTER XI. DISCIPLINE

PART 1. COMPONENT SOCIETY PROCEDURE

Section 3. [Charges Initially Presented to the Illinois State Medical Society. Original complaints received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee.] *Formal written charges presented to the Illinois State Medical Society. Formal written charges received by the Illinois State Medical Society shall be referred directly to the secretary of the component society of which the accused is a member or to the district Ethical Relations Committee in the event that the component society does not have an Ethical Relations Committee.*

Section 4. Principles of Justice. The following principles of justice shall guide the Ethical Relations Committee in all disciplinary procedures.

A. An accused is presumed to be innocent until he has been proven guilty.

B. [Formal charges before the Ethical Relations Committee of the component society or district Ethical Relations Committee must be presented under oath by the complaining party.] *No proceeding shall be initiated under this Part 1 until formal written charges have been filed with the secretary of the component society or the district Ethical Relations Committee, as the case may be. Thereafter, said formal written charges must be presented under oath by the complaining party before the Ethical Relations Committee of the component society or the district Ethical Relations Committee, as the case may be.*

C. [A trial shall be held by the committee within 30 days after the formal charges have been filed, unless continued by the chairman of the committee upon good cause shown.] *In the event that a component society's Ethical Relations Committee does not make a good faith effort to hold the trial within the time period, including reasonably granted continuances, either the complaining party or the physician, against whom formal written charges have been brought, may appeal for relief and trial to the district Ethical Relations Committee.*

Section 6. Verdict. The committee, sitting as a trial

body, shall [find] *recommend* the accused *be found* either guilty or not guilty. If the verdict is guilty, the trial body shall recommend censure, suspension or expulsion.

The findings of the trial body must be presented to the component county society for approval or rejection. The accused must be notified by certified mail at least ten days before the date set for the meeting at which this action will be taken. If the findings of the [trial body] *component society* are against the accused, the secretary of the component society shall acquaint the accused, by certified mail, with his right of appeal within thirty days to the Board of Trustees of the Illinois State Medical Society.

Brackets delete; italics add.

Resolution 75A-7

Introduced by: Theodore Grevas, M.D., for the Rock Island County Medical Society
Subject: Assistance for PSRO Organizations
Referred to: Reference Committee B

WHEREAS, The House of Delegates of the Illinois State Medical Society on November 10, 1974, authorized development of an Illinois Peer Review Organization outside the purview of the federal PSRO system, including the expenditure of funds for such purpose; and

WHEREAS, Such expenditure of effort and funds results in an unnecessary duplication of review systems involving a minority of physicians in the State of Illinois; therefore, be it

RESOLVED, That the Illinois State Medical Society shall cease and desist forthwith from providing any assistance in establishment or support of an organization outside the federal PSRO system; and be it further

RESOLVED, That the Illinois State Medical Society shall render assistance to PSRO organizations in the State of Illinois, including designation as a State Support Center if necessary; and be it further

RESOLVED, That special assessment funds not already spent be used for education and implementation of efforts to repeal, amend, or improve Public Law 92-603 and to assist in compliance with the law.

Resolution 75A-8

Introduced by: Jack L. Gibbs, M.D., for the Fulton County Medical Society
Subject: Malpractice Insurance Coverage
Referred to: Reference Committee F

WHEREAS, The threat of malpractice and the inability of some physicians to get malpractice insurance has begun to have a detrimental impact on health care and physicians' ability to provide good health care; and

WHEREAS, There has been significant withdrawal of malpractice insurance coverage in the state and there exists the very real possibility of future withdrawal of all malpractice coverage in the state; and

WHEREAS, There has been a significant number of cancellations of groups, high risk physicians and even state groups; and

WHEREAS, There is an inability of some high risk specialty physicians to obtain any insurance; and

WHEREAS, There is a need for insurance, not only for the protection of the physician but also for the protection of the patient; therefore, be it

RESOLVED, That the Illinois State Medical Society and the American Medical Association devote all possible resources to a multifaceted approach to solution (s) of the problem of professional liability insurance coverage; and be it further

RESOLVED, That we endorse the concept of effective peer review by a committee of physicians appointed by the ISMS to review all questions of malpractice coverage, including both new applications and cancellations of existing policies; and be it further

RESOLVED, That the physician has a right to personally appear before the peer review committee in all questions of obtaining malpractice coverage and/or in the question of cancellation; and be it further

RESOLVED, That the ISMS seek assurance from the insurance company that if the committee finds in favor of the physician, that the insurance company will be bound to provide coverage; and be it further

RESOLVED, That the ISMS be urged to take immediate steps to formulate model legislation and interim emergency legislation, outlined by the AMA proposals on malpractice insurance; and be it further

RESOLVED, That the membership be given frequent and timely progress reports on the problem.

Resolution 75A-9

Introduced by: Joseph R. O'Donnell, M.D., for the DuPage County Medical Society
Subject: Officer elections
Referred to: Reference Committee A

WHEREAS, It is increasingly important that the officers of Illinois State Medical Society be truly representative of the wishes of the House of Delegates; and

WHEREAS, Election to these offices should be by the House of Delegates at an official meeting; and

WHEREAS, At present a caucus (of either District III or Downstate Districts) selects the nominees to be presented to the House of Delegates for each office, thus giving the House of Delegates only the option of ratifying the selections; therefore, bt it

RESOLVED, That the offices of president-elect, treasurer and secretary of the Illinois State Medical Society be filled by having the caucus present to the House of Delegates two nominations for each office, insuring that the House can vote on the candidate of its choice.

Resolution 75A-10

Introduced by: Joseph R. O'Donnell, M.D., for the DuPage County Medical Society
Subject: Redistricting
Referred to: Reference Committee G

WHEREAS, The Illinois State Medical Society Board of Trustees is composed of representatives from trustee districts of Illinois State Medical Society and these trustee districts were formed in about 1948; and

WHEREAS, There is a demand on the part of local medical societies for more direct representation on the interior policy-making bodies of the Illinois State Medical Society; and

WHEREAS, A committee to study redistricting of the Illinois State Medical Society was named in both 1971 and 1972 but chose to take no action on the assignment; and

WHEREAS, The present districts as they are now defined are no longer representative of many of the Illinois State Medical Society county medical societies, by reason of changes in practice patterns within the individual districts, as well as the federal district mandate; therefore, be it

RESOLVED, That a survey of component medical societies be made to evaluate the present trustee districts; and be it further

RESOLVED, That the Illinois State Medical Society trustee districts be reformed to make them more representative of their areas; and be it further

RESOLVED, That the redistricting be completed and reported back to the House of Delegates by October 1, 1975, and acted upon by the House of Delegates at its 1976 annual convention.

Resolution 75A-11

Introduced by: A. Edward Livingston, M.D., for the Committee on Constitution and Bylaws
Subject: Amendment to Chapter VII of the Bylaws
Referred to: Reference Committee on Amendments to Constitution and Bylaws

WHEREAS, The bylaws do not provide for anyone to assume the responsibilities of the Chairman of the Board of Trustees in his absence; therefore, be it

RESOLVED, That such provision be made by amending Chapter VII, Section 5 as follows:

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. *The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.*

Item in italics to be added.

Resolution 75A-12

Introduced by: Eugene L. Vickery, M.D., for the Medical-Legal Council
Subject: Pharmaceutical Package Insert, Limitation
Referred to: Reference Committee E

WHEREAS, Recent court decisions, through the Illinois Supreme Court, have identified the package insert as the standard of care, eliminating the need for expert medical testimony as to the standard of care, and identifying deviation from the package insert as *prima facia* evidence of negligence; and

WHEREAS, The Food and Drug Administration has clarified the legal status of labeling and clarified the use of the package insert with the following statement:

"Once a prescription new drug has been shipped in interstate commerce intended for its approved use (s) under approved labeling, the Federal Food, Drug and Cosmetic Act (FD&C Act) does not require a physician to file with the FDA an investigational new drug plan (IND) in order to lawfully prescribe the drug for an unapproved use, when such prescribing is done as part of the practice of medicine."

and,

WHEREAS, Requirements in the Federal Food Drug and Cosmetic Act, as to "approved use" relate to marketing and labeling, and "unapproved use" is simply a use not indicated in the labeling, which use may not be approved simply because it has never arisen as an issue and does not mean that such use is disapproved; and

WHEREAS, Clinical experience and judgment of physicians often is not reflected in the labeling, thus negating the application of the package insert as establishing a standard of care; therefore, be it

RESOLVED, That it be the policy and position of this House that the package insert labeling of pharmaceutical preparations, as well as the PDR, is identified only as a guide, a recordation of specific types of application of the product, not as an absolute standard limiting the practice of medicine; and be it further

RESOLVED, That the full content of this resolution be submitted to the AMA House of Delegates by the ISMS delegation, requesting that this policy also be AMA policy and that the AMA make every effort to have federal legislation introduced so as not to compromise the ability to help patients and practice medicine by misapplication of the package insert.

Resolution 75A-13

Introduced by: Eugene L. Vickery, M.D., for the Medical-Legal Council
Subject: Non-endorsement of Resolution 74A-51A
Referred to: Reference Committee E

WHEREAS, Resolution 74A-51A, introduced to the 1974 House of Delegates, called for expressions of public concern for problems besetting attorneys and offering the medical society's good offices to set up a peer review mechanism, and also called for the AMA to assist the legal profession in reviewing its educational programs so as to correct professional and moral deficiencies; and

WHEREAS, Resolution 74A-51A was referred to the Medical-Legal Council for study and recommendation, which has been accomplished; therefore be it

RESOLVED, That it be recognized that Resolution 74A-51A is a sincere attempt to try to identify to our lawyer colleagues that by their internal activities understanding of the problems in medical professional liability would be enhanced; and be it further

RESOLVED, That the medical and legal professions must work harmoniously for the public good in solving the multifaceted dilemma of professional liability and claims of malpractice, and to this end it is the sense of this House that there is encouragement and support for activities by the Board of Trustees to develop solutions in concert with the Bar Association; and be it finally

RESOLVED, That Resolution 74A-51A be not endorsed.

Resolution 75A-14

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Psychosurgery
Referred to: Reference Committee D

WHEREAS, Psychosurgery, as one of the organic therapies applied in treatment of brain dysfunction, is poorly comprehended by lay persons and often may be misunderstood by the medical profession; and

WHEREAS, A need exists for description of the term and the procedure called psychosurgery to enable appropriate response to those requesting such; therefore, be it

RESOLVED, That the following description of Psychosurgery be endorsed as the position of the Illinois State Medical Society:

Psychosurgery refers to those surgical operations which irreversably destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms, and chronic pain syndromes, nor does it include non-surgical electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation, and reasoned consent.

Resolution 75A-15

Introduced by: Eugene L. Vickery, M.D., for the Medical-Legal Council
Subject: Professional Liability
Referred to: Reference Committee F

WHEREAS, Resolution 74A-21, adopted by the 1974 House of Delegates, mandated investigation and development of alternatives as such relate to the attorney contingent fee system, while protecting patients' rights; and

WHEREAS, The Medical-Legal Council has investigated and discussed many proposals in the vexing and insidious situation by which claims of medical malpractice are seemingly almost frivolously entered, also recognizing that this situation is increasing the cost of health care and diluting the availability of medical manpower; and

WHEREAS, No easy solutions are recognized, the attorney contingent fee system is only one facet of the problem, and a continued effort is necessary to identify possible activities and to develop proposals; therefore, be it

RESOLVED, That there is encouragement for continued study of problems inherent in the medical professional liability situation by the Medical-Legal Council; and be it further

RESOLVED, That appropriate procedures be developed within the State Medical Society, that appropriate remedial legislation be developed, or that appropriate programs be studied or implemented, in concert with other professional associations when necessary, related to, but not limited to, the following concerns:

1. Accomplishment of peer review under local medical societies to rehabilitate, reeducate or remove licensure, within a new disciplinary system;
2. Modification or elimination of the legal profession contingent fee system in medical professional liability action;
3. Establishment of medical screening panels for incidents which might lead to a claim of medical malpractice;
4. Development of a mediation/conciliation court system within the Illinois judiciary;
5. Modification of the statute of limitations to a reasonable time after occurance;
6. Elimination of the ad damnum prayer, the plea for specific dollar awards as damages;
7. Continued development of arbitration as one means of resolving differences;
8. Promotion of single incident insurance availability for patient purchase to guard against loss should there be a medical maloccurrence;
9. Requirement for carriers to disclose detailed claims experience and actuarial data to better identify the climate; and
10. Establishment of a medical maloccurrence commission to set maximum awards in medical injury situations.

Resolution 75A-16

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Community Mental Health Center Support
Referred to: Reference Committee D

WHEREAS, There is a current fallacy that Community Mental Health Center care is the most effective and humane form of care for the majority of mentally ill individuals and excels care provided by the private sector; therefore, be it

RESOLVED, That ISMS, through appropriate channels, request that the AMA cease preferential support of all further Community Mental Health Center extension legislation in order to permit psychiatric patients to maintain a choice of physician in a pluralistic system of health care delivery.

Resolution 75A-17

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Reaffirmation of Position Regarding Diagnosis and Treatment of Mental Disorders
Referred to: Reference Committee D

RESOLVED, That the ISMS delegation to the American Medical Association introduce the following resolution at the June, 1975, meeting of the AMA House of Delegates:

"RESOLVED, That the American Medical Association, in keeping with Resolution 169 (A-74), reaffirm that any legislation that would authorize non-physicians to engage in the diagnosis or independent treatment of mental, emotional or nervous disorders is in conflict with the public interest; and be it further

"RESOLVED, That any legislation which would authorize non-physicians to prescribe drugs or medication in any form for any purpose is also in conflict with the public interest; and be it further

"RESOLVED, That the constituent state societies be promptly informed by special communication of this action of the House; and be it further

"RESOLVED, That state societies where existing law or pending legislation is in conflict with the above resolutions be officially informed without delay of this supportive action of the House."

Resolution 75A-18

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Medical Service by Non-Physicians
Referred to: Reference Committee B

WHEREAS, Recently enacted PL 93-363 equates psychologists and optometrists to doctors of medicine for provision of medical services to government employees under health insurance policies; and

WHEREAS, This law inappropriately provides for an initial point of entry into medical care by non-medical professional activity, which is not in the best interest of those requiring medical care; therefore, be it

RESOLVED, That the ISMS Delegation to the AMA be instructed to enter the following resolution at the next AMA meeting:

"RESOLVED, That PL 93-363 is contrary to the well-being of government employees in need of health care, and that the AMA work to repeal or modify this law; and be it further

"RESOLVED, That if under any governmental health insurance program non-medical services are to be reimbursed, a separate category for such reimbursement should be established and be optional to the insured."

and be it further

RESOLVED, That this Resolution be expressed as the position of the ISMS in this regard.

Resolution 75A-19

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Equalization of Medicare Benefits for Psychiatric Illness
Referred to: Reference Committee B

WHEREAS, There has been identified a lack of coverage for benefits to Medicare recipients as such relates to psychiatric illness; therefore, be it

RESOLVED, That the Illinois State Medical Society ask the American Medical Association to actively seek to end inappropriate and unnecessary discrimination against in-patient and out-patient medical benefits to Medicare beneficiaries afflicted with psychiatric illness, as such relates to active treatment by a physician licensed to practice medicine in all its branches; and be it further

RESOLVED, That it be the position of the Illinois State Medical Society that benefits for psychiatric illness under Medicare should be equal to benefits as for any other medical condition.

Resolution 75A-20

Introduced by: Kermit T. Mehlinger, M.D., for the Council on Mental Health and Addiction
Subject: Inclusion of Mental Illness under any Proposed National Health Insurance
Referred to: Reference Committee B

WHEREAS, Various proposals for a program of insurance for health care under Federal Government auspices have been put forth; and

WHEREAS, Psychiatric illness and mental health have been omitted or seriously reduced in coverage under proposed National Health Insurance, discriminating against this health need of the public; therefore, be it

RESOLVED, That ISMS advocate, through its Governmental Affairs Council as well as by resolution to the AMA, that psychiatric illness, in all its forms, be given equal coverage as for any other medical illness, for active medical treatment by a fully licensed physician, under any proposed governmental insurance programs.

Resolution 75A-21

Introduced by: James P. Campbell, M.D., for the DuPage County Medical Society
Subject: The Relationship of Medical Diagnosis to Prognosis and Treatment
Referred to: Reference Committee B

WHEREAS, The prime responsibility of the practicing physician is the rendering of adequate and proper treatment to the patient; and

WHEREAS, Government programs and third party carriers do not render direct medical care and are not fully cognizant of individual patient treatment requirements; therefore, be it

RESOLVED, That government officials and third party carriers be informed and educated to abide by the principles of the relationship of medical diagnosis to prognosis and treatment; and be it further

RESOLVED, That this be done to protect the welfare of patients.

Resolution 75A-22

Introduced by: Edward G. Ference, M.D., for the Sangamon County Medical Society
Subject: Pursuit of "No Fault" Professional Liability Insurance through State and Federal Legislation
Referred to: Reference Committee F

WHEREAS, Physicians in some states have experienced non-renewal of previously secure professional liability insurance protection; and

WHEREAS, The spectre exists that physicians practicing in Illinois may, likewise, find that professional liability insurance protection could be withdrawn without sufficient advance notice to replace it with other suitable protection; and

WHEREAS, Costs to the patients for medical care are directly affected by the expense of premium costs for professional liability insurance, and premium costs, and consequently added charges to the patient, have increased abnormally due to claims made thru expensive legal recourses; therefore, be it

RESOLVED, That the ISMS move with all possible dispatch to thoroughly review the current professional liability insurance problem and to promptly recommend corrective federal and state legislation to the appropriate bodies, with particular attention to the "No Fault" concept.

Resolution 75A-23

Introduced by: Robert P. Johnson, M.D., for the Sangamon County Medical Society
Subject: Peer Review
Referred to: Reference Committee B

WHEREAS, The House of Delegates of the Illinois State Medical Society meeting in special session on November 9-10, 1974 promulgated an encompassing resolution to establish the policy of the Illinois State Medical Society toward Peer Review; and

WHEREAS, The fifth resolved states:

"RESOLVED, That those component societies which choose not to seek PSRO designation, be provided with an Illinois Peer Review organization—under the auspices of ISMS or its designated arm and out of the purview of the federal PSRO Program—at the option of the majority of the component society members of the organization;"

WHEREAS, To provide those component societies referred to above, or their designated Peer Review Units, with an organization of state-wide strength who may deal with all levels of authority from a demonstrated posture of unity in the State of Illinois, we submit the following RESOLVES, to follow the above quoted RESOLVE from previous house action and accordingly amend that resolution by addition; therefore, be it

RESOLVED, Each Peer Review Unit designated by a component society shall be instructed to provide proportional representation to a state-wide council which will serve to speak the unified opinion of the constituents Peer Review Organizations; and be it further

RESOLVED, That PSRO designees of component societies may elect to be part of the above unified council if they wish to join this voice from the state.

Resolution 75A-24

Introduced by: James W. Sutherland, M.D.
Subject: Limitation of Practice of Acupuncture to Fully Licensed M.D.s and Osteopaths
Referred to: Reference Committee F

WHEREAS, As a result of the recent interest in acupuncture a veritable plague of practitioners of this procedure has arisen; and

WHEREAS, These practitioners lack the necessary training to practice medicine; and

WHEREAS, Our county medical society has received repeated complaints from patients defrauded by such practitioners; and

WHEREAS, There is a gray area in the legislation regarding the practice of acupuncture which neither allows nor forbids these practitioners from performing those procedures; therefore, be it

RESOLVED, That the Illinois State Medical Society put forth its best efforts to have legislation passed limiting the practice of acupuncture to fully licensed M.D.s or osteopaths under penalty of the law.

Resolution 75A-25

Introduced by: Herman Wing, M.D.
Subject: Confidentiality and PSRO
Referred to: Reference Committee E

WHEREAS, The physicians of the United States have been requested to comply and cooperate with the furtherance of PSRO (PI 92-603); and

WHEREAS, The practice of medicine is not an exact science and the contract with a patient includes a mutual and confidential relationship; and

WHEREAS, The practice of medicine is an art and the methods of practice although skillful and competent, often offer variable alternatives which are part of the judgment mechanisms in the practice of medicine; and

WHEREAS, The physicians of the United States are always striving to provide their patients with good medical care which requires mutual respect and confidentiality so that the patient's trust can be wholesome and his privacy not violated; and

WHEREAS, Court decisions protect the patient's right of privacy; and

WHEREAS, Recent actions of the Congressional and Executive Branches of the United States government uphold the citizen's right of privacy in all aspects of his life; and

WHEREAS, Self-appointed consumer groups, who allege to represent masses of the population, are now advocating and petitioning the PSRO to destroy the confidential relationship between patient and physician; and

WHEREAS, In furthering these goals they are continuing to pressure the federal government to make available to anyone the doctor's personal and private patient records, their opinions concerning diagnosis and treatments, and other information given by patients on the basis of trust; and

WHEREAS, These tactics will undermine personal and private practice of medicine in the United States; therefore be it

RESOLVED, That the Illinois State Medical Society urge AMA to seek amendments to the PSRO Law (PL 92-603) to ensure the protection of the patient's right to privacy and confidentiality; and be it further

RESOLVED, That the Illinois State Medical Society take immediate action to further the principle of confidentiality; and be it further

RESOLVED, That violations of the doctor-patient confidentiality by PSRO officials be logged by ISMS for periodic reporting to the House of Delegates; and be it further

RESOLVED, That ISMS encourage physicians to discontinue cooperation with PSRO if violations of confidentiality and privacy become apparent and that AMA be urged to take a similar position.

EDUCATIONAL & SCIENTIFIC PROGRAM BY DAY

Monday, March 31

Two day Symposium for Nurses

Tuesday, April 1

Instructional Course in Medical Direction in Long Term Care Facility

Wednesday, April 2

Pediatrics
Dermatology
Plastic Surgery
Allergy
Gastroenterology
Instructional Course in Endocrine & Metabolic Disorders
Laryngology & Otology
Instructional Course in Medical Treatment of Kidney Stones
Medical Assistants
Conference Feature Hour
Film Lectures
Neurology
Urology

Thursday, April 3

Rheumatism
Chest Problems
Instructional Course in Gastroenteriology
Instructional Course in Antibiotic Usage
Film Lectures
Trauma Program & Orthopedics
Berkheiser Lecture
Conference Feature Hour
Preventive Medicine

Friday, April 4

Surgery
OB-GYN
Heart
Instructional Course in Allergy & Clinical Immunology
Instructional Course in Dermatologic Problems
Film Lectures
Conference Feature Hour
Internal Medicine

Saturday, April 5

Anesthesiology
Ophthalmology

An Educational Program From ISMS In Cooperation With the AMA

"A PRACTICAL LOOK AT MEDICAL DIRECTION IN LONG-TERM CARE FACILITIES"

The Challenge and Management of the Long-Term Care Patient

The Professional and Financial Opportunities For Groups or Individual Practitioners To Participate On A Full or Part Time Basis

The Many Roles of the Medical Director

The Everyday Responsibilities

The Relationships With the Administrator, Nursing Staff, Allied Personnel, and Other Physicians

The Impact of New State and Federal Regulations

April 1-2, 1975, McCormick Place, Chicago

Accreditation:
Acceptable for 14 credit hours in Category #1 for the Physician's Recognition Award.
Acceptable for 14 elective hours by the American Academy of Family Physicians.

Pre Registration Required, for information call: Mr. Larry Boress, 312-782-1654

MEDICAL LIABILITY AND THE DOCTOR DEFENDANT

April 3, 1975 **McCormick Place, Chicago**

9:00 a.m.	Introduction Herman Wing, M.D., LI.B., Program Chairman	
9:10 a.m.	The Physician	Mr. John Stimpson Vice President, Johnson and Higgins
	The Hospital	Mr. James Zahour, Claims Manager Argonaut Insurance Co.
9:30 a.m.	From the Litigating Patient's Viewpoint	Mr. John Hayes, Attorney Hayes and Associates, Ltd.
9:50 a.m.	From the Defendant Physician's Viewpoint	Mr. John White, Attorney McKenna, Storer, Rowe, White & Haskel
10:10 a.m.	Anatomy of a Malpractice Claim	Mr. Harold Jacobson, Attorney Lord, Bissell and Brooks
10:30 a.m.	Physicians Look at Malpractice	Herman Wing, M.D., LI.B. Donal O'Sullivan, M.D., J.D.
10:50 a.m.	Legislative Viewpoint	
11:10 a.m.	Panel Discussion	Leonard Klafta, M.D., Chairman, ISMS Medical Legal Council Mr. William McKenna, Illinois State Bar Assoc.

Presented in co-operation with the Chicago Academy of Law and Medicine

Medical Management of Alcoholism

April 3, 1975 **McCormick Place, Chicago**

9:00 a.m. Le Roy P. Levitt, M.D., *Director,* llinois Department of Mental Health,
Chairman of Morning Session

9:05 a.m. Charles E. Becker, M.D., *Head,* Division of Clinical Pharmacology, Director Acute Detoxification Study Unit, San Francisco General Hospital.
"Treatment of Acute Alcoholism"

10:45 a.m. Charles S. Leiber, M.D., *Professor of Medicine,* Mount Sinai School of Medicine. Chief, Section of Liver Diseases and Nutrition, Bronx, V.A. Hospital.
"Alcoholic Liver Disease"

1:15 p.m. Jan A. Fawcett, M.D., *Professor and Chairman,* Department of Psychiatry, Rush Presbyterian-St. Luke's Medical Center
Chairman of Afternoon Session.

1:30 p.m. Maxwell N. Weisman, M.D., *Director,* Division of Alcoholism Control, State of Maryland.
"Rehabilitation of the Alcoholic Patient"

3:15 p.m. ***Panel*** - Joyce C. Lashof, M.D., *Moderator*
Director, Illinois Department of Public Health
Participants—Charles E. Becker, M.D.
Charles S. Lieber, M.D.
Maxwell N. Weisman, M.D.
Vincent D. Pisani, Ph.D.

Sponsored By: Committee on Alcoholism and Drug Abuse
Illinois State Medical Society
W. David Steed, M.D., Chairman

Program Chairman—James W. West, M.D.

Supported in part by a grant from the Illinois Department of Mental Health and from Ayerst Pharmaceuticals Laboratories

Limited to Physicians

Physicians and Auxiliary of the Illinois State Medical Society are cordially invited to a complimentary Public Affairs Breakfast

featuring



Honorable Michael J. Howlett

Secretary of State

8:00 a.m. Friday, April 4, 1975

Room VII, McCormick Inn

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

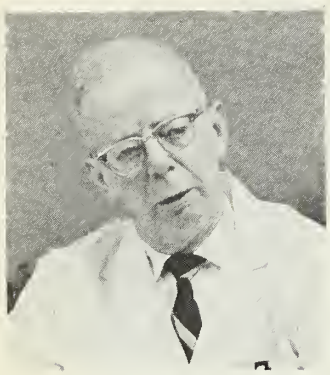
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Mead Johnson LABORATORIES



President's Page

FINALE

I compose this final communication to you—the members—with mixed emotions. Being a procrastinator at heart—as well as in fact—has made meeting the publication deadlines a nightmare. Hence, it is with a sense of relief that I pen this final "page." However, I have enjoyed the opportunity to share with you my views on some of the crucial issues facing the profession, and will miss the ventilation this forum has afforded.

I face this finale with ambivalence on another plane. I am distraught because our profession—which has propelled medicine to a pinnacle of pre-eminence in the world—is under such broad attack at home, and I am aghast that these assaults are met with such vast apathy. However, I am heartened by the dedicated cadre of talented leaders hard at work throughout the state in medicine's behalf.

It is appalling to me that the membership at large is oblivious to the current crisis which threatens our profession. I am not referring to the much touted "health care crisis," but rather to the crisis of professional freedom—the escalating government intrusions into our professional conduct perpetrated through legislation and regulation.

When will our members awaken? How can we arouse them?

We are doomed to the fate of medicine in England if we cannot rally the profession to a united defense against the assaults being launched against us on many fronts. It is time for a missionary effort by the few active members to enlist the interest and participation of the inactive many. We need to revive the spirit and involvement of our colleagues.

We also need a major reshaping of "organized medicine" to reflect the changes wrought in our professional lives and associations. The exponential growth of the specialties and their organizations has vitiated the effectiveness of the present organizational structure. This effectiveness also has been weakened by the explosive expansion of metropolitan areas which has virtually destroyed the community of interest previously shared by members of county medical societies in those areas.

In large measure, the present structure is an anachronism. We must find a means to restructure and more fully integrate the specialty societies and their individual members into the fabric of "organized medicine."

Fredric D. Lake

Fredric D. Lake, M.D.

Doctor's News

A BILL CALLING FOR STUDY OF MEDICAL LIABILITY INSURANCE problems was introduced by Congressman Dan Rostenkowski, chairman of the House Subcommittee on National Health Insurance. The study would be conducted by the Office of Technology Assessment and the National Academy of Sciences, with a report to be submitted by May 1, 1976.

Other bills are being developed. At the time of writing these were

- HR 1385 (Holt, Md.) to establish a commission on amounts of awards in liability settlements.
- S 188 (Nelson, Wis.) to authorize HEW to establish a reinsurance fund and to conduct studies and experiments.
- S 482 (Kennedy, Mass. and Inouye, Hi.) to mandate a no-fault plan eliminating contingency fees but subjecting physicians to PSRO standards. Not being subject to such standards the law would not apply.
- S 213 (Inouye, Hi. and Kennedy, Mass.) establishes compulsory arbitration in claims of medical negligence.

Related to this, the American Hospital Association is moving to capitalize a captive insurance company, which would market coverage through a national casualty insurance company. Enrollees would include hospitals, house staff, hospital employees and physicians under contractual relationships with hospitals.

Upon action of the Board of Trustees, ISMS is working assiduously at development of remedial legislation to be introduced in the Illinois General Assembly. In addition, the initial five hospitals to be enrolled in the Pilot Hospital Arbitration Project which has been under development have been identified.

THE NATIONAL ENDOWMENT FOR THE HUMANITIES has announced five Humanities Seminars for physicians and other members of the health professions. These seminars will examine basic issues bearing on medical practice in their ethical, philosophical, historical, and social contexts. It is the Endowment's hope that the program will attract present and future leaders in the medical profession and help to improve the quality of leadership.

The seminars will be directed by Dr. John C. Burnham of Ohio State University, June 23-July 18; Dr. H. Tristram Engelhardt, Jr. of the University of Texas Medical Branch at Galveston, September 8-October 3; Dr. Renee C. Fox of the University of Pennsylvania, June 2-June 30; Dr. Leon R. Kass of the Kennedy Institute at Georgetown University, July 27-August 22; and Dr. William F. May of Indiana University, June 29-July 25. There will be 12 to 15 participants chosen for each seminar. They will attend tuition-free and receive stipends of $1,200 plus a travel allowance of up to $300.

Interested persons can obtain further information from: Julian F. MacDonald, Program Officer, Division of Fellowships, National Endowment for the Humanities, Washington, D.C. 20506. Deadline is April 1.

CONTINUING MEDICAL EDUCATION CONGRESS scheduled April 18 and 19, at the Chateau Louise, Dundee. This Third Annual Illinois Congress will bring together physicians and representatives of medical schools and specialty societies throughout Illinois to discuss the role of medical schools in continuing education and the establishment of a comprehensive CME program for the state. The keynote speaker, Robert Evans, M.D., Dean, Rockford School of Medicine, will discuss the relationship between medical education and the quality of care. He will give his address in three parts with small group discussions following each section. The sessions are entitled: 1) "Hospitals and Medical Schools—Their Roles in a Pyramid of Care and Education"; 2) "The United Approach of Community Hospitals in CME"; and 3) "Role of the Medical School in CME".

Physicians attending the Congress will earn nine hours of AMA Category I credit toward the Physician's Recognition Award. Registration is limited to 100 participants. There is a $35 fee for tuition, the Friday evening banquet, and the costs of the Congress syllabus and final report. Reservation deadline is April 4. For additional information, contact: ICCME, 55 E. Monroe St., Chicago, 60603, or phone: (312) 236-6110.

PHYSICIANS IN THE NEWS—New officers of the Illinois Obstetrical and Gynecological Society for 1975 are president—**John J. McLaughlin, Jr., M.D.**, Joliet; president elect—**Stanley E. Smith, Jr., M.D.**, Urbana; vice president—**Richard Whitlock, M.D.**, Elgin; secretary—**J. Roger Powell, M.D.**, Urbana; assistant secretary—**Robert Maletich, M.D.**, Springfield; and treasurer—**Robert W. Rieman, M.D.**, Ottawa.

The newly elected president of the Medical Staff at St. Joseph's Hospital is **Cyril C. Wiggishoff, M.D.**, Chicago, Third District Delegate to ISMS.

Oglesby Paul, M.D., vice president for Health Sciences at Northwestern University has been named the first J. Roscoe Miller Professor of Medicine at Northwestern. He also received the Chicago Heart Association's most distinguished award, the Coeur d'Or, for his contributions to the control and prevention of heart disease.

The twentieth named faculty position has been established at Rush-Presbyterian-St. Luke's Medical Center. **George M. Hass, M.D.**, was named to this position as the first Otho S.A. Sprague Professor. Dr. Hass has been the leader in research focused on the degenerative disease, arteriosclerosis.

When Presidents Meet



Gerald J. Menaker, M.D., newly elected president of the Medical Staff of Michael Reese Hospital and Medical Center, (left) officiated recently at the presentation of a testimonial plaque to the outgoing president, S. Lloyd Teitelman, M.D., who is a new member of the center's Board of Trustees, (right). Other new members of the Medical Staff are Arthur A. Billings, M.D., president-elect, and Richard Shapiro, M.D., secretary-treasurer. Harvey Horwitz, M.D., was selected for the Medical Staff's Thirty Year Award.

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ROBITUSSIN A-C®	●	●			
ROBITUSSIN-DM®	●	●	●		●
ROBITUSSIN-PE®	●			●	●
ROBITUSSIN®-CF	●	●		●	●
COUGH CALMERS®	■	■	■		■

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American Association of Medical Assistants
Illinois Society — 19th Annual Convention

Unlimited Horizons

Holiday Inn South
Rt. 80, Larkin Ave., Joliet

April 24-27, 1975

Thursday, April 24, 1975

8:00 p.m. Official Opening of Exhibits
8:30 p.m. Hospitality Parties

Friday, April 25, 1975

8:00 a.m. Council Meeting
10:00 a.m. House of Delegates
11:00 a.m. President - President Elect Luncheon
12:30 p.m. Reference Committees
3:15 p.m. House of Delegates Reconvenes
*8:00 p.m. Presidents Dinner

Saturday, April 26, 1975

*8:00 a.m. Continental Breakfast
9:15 a.m. "Office Productivity"
Dr. Robert J. Kramer, M.D., FACS
10:30 a.m. "Rape and Evidence"
Mr. Rey Rossi, Evidence Technician, Officer Robert Boucher
*12:30 p.m. Awards Luncheon
2:00 p.m. "Euthanasia" Panel
Dr. Leonrd A. Klafta, M.D., FACS, Judge Michael Orenic, and Rev. John Huff
3:05 p.m. "Clinical Hypnosis"
Mr. Philip Bonelli
9:00 — 10:00 a.m. and 2:00 — 3:00 p.m.
Mini Certification Test (AAMA)
Miss Phyllis Bredthauer, CMA
*7:00 p.m. Installation Banquet
10:00 p.m. President's Reception (Dancing)

Sunday, April 27, 1975

9:00 a.m. Breakfast (Farewell) "Motovation"
Mrs. Jean Mobley, CMA-AC
AAMA Trustee
11:00 a.m. Council

*Meals included in general registration fee.

Convention Registration Chairman:
Mrs. Shari McNamara
3116 Harris Drive
Joliet, Illinois 60435



The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

Malpractice - Two Separate Problems

The day is rapidly approaching when physicians in some states may not be able to purchase liability insurance at any price. Already in some areas liability insurance premiums cost more than the *gross* income of physicians beginning their practice. In other areas neurosurgeons are refusing to accept emergency-room cases because of the liklihood of a malpractice suit.

Patients too are suffering. Not only is the patient paying more in physician's fees to cover the cost of malpractice insurance; but the patient is also paying the cost of defensive medicine, i.e. more laboratory tests and consultation fees. Furthermore, the bureaucracy of the malpractice litigation system absorbs close to 84% of the awards given. The unfortunate victim of malpractice receives only 16%, after lawyers fees, court costs, and other expenses are taken out.

During this malpractice crisis it has been popular to place blame on financially motivated, self-serving trial lawyers who seek to take advantage of liberal-minded juries. In a similar fashion, many people reproach the general population for expecting cures for every illness and protection against every misfortune life bestows. The insurance companies have been accused of absurdly high premiums and deserting the principles of truth and justice for the expediency of settling out of court. Congress and state legislatures have been held responsible for inaction in putting a stop to the malpractice circus. Juries have been condemned for apportioning absurdly high awards to claimants of marginal malpractice claims, and for adopting the attitude that even though the doctor was not at fault, *someone* should compensate the poor victim.

While there may be an element of truth to each of these claims, perhaps we should focus on ourselves. It is possible that *we* are to blame for the current crisis. None of us set out to create this crisis, and none of us planned the crisis, but by our inaction we have allowed the crisis to develop.

Malpractice litigation in theory serves two functions: it allows financial compensation for the unfortunate victim of injurious, unprofessional treatment, and it financially punishes the physician who performs that treatment. Unfortunately, malpractice litigation serves neither of these two functions in reality. Most victims are not compensated, while a few are overcompensated for ridiculous or imagined injuries. Furthermore, the truly deserving victim receives only a fraction of what was intended for him.

The guilty physician, aside from some embarrassment and perhaps a rise in his insurance rates, is not legitimately punished. Instead insurance companies and other physicians bear the consequential loss in financial and professional confidence. At the very worst, the guilty physician may lose his hospital privileges, his county medical society membership, and be forced to move to another county to practice medicine. But even that extreme is rare.

Why then, if malpractice litigation doesn't perform its job adequately has it been allowed to exist and thrive? Perhaps because physicians have not accepted the leadership in dealing with this problem. The American public *demands* that innocent victims of medical malpractice be compensated. Mistakes will occur, even with the best medical care, and the people believe that individuals who suffer from such mistakes should receive some compensation for their loss. The man who enters the hospital for a hernia repair and by mistake has his leg amputated should not suffer his loss without financial aid. The patient who suffers the pain and risks of a second operation to remove a surgical sponge should receive compensation.

It makes little difference whether we as physicians agree with the philosophy that patients should be compensated for medical mal-occurences. The fact is that the public demands it. The American public's toleration of the current malpractice litigation system, with all of its faults, is strong evidence that the people *will satisfy* their demand for compensation. The physicians' failure, through inaction, to provide any system of compensation for innocent victims has virtually forced these victims into the waiting arms of the legal profession for help.

Another demand of the American public which physicians have ignored is that of protecting the public from bad doctors who practice second and third-class medicine. While most physicians are both dedicated and skilled in their work, there are those whose level of competence is far below that of a junior medical student. There are physicians allowed to practice medicine whose addiction to drugs or alcohol make them dangerously unsafe on the roads, let alone in the operating theater.

There are physicians whose only attempt to keep abreast of the changes in medicine in the last twenty years has been to occasionally skim a medical journal. There are other physicians who religiously read journals, attend post-graduate classes, and memorize textbooks, but whose clinical judgement is so poor that they are unable to bridge the gap from theory to practice.

We have failed to provide any reasonable mechanism for dealing with these problems. In some instances, the flagrant drug or alcohol addict can have his license suspended or revoked, but that is a rarity. At worst, the physician who consistantly displays poor clinical judgement or poor operative technique may have his hospital privileges suspended. In no way does that "punishment" protect the public.

(Continued on page 266)

surgical grand rounds

Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of October 1, 1974.

Subclavian Aneurysm

Dr. Jack Swelstad: A 63-year-old, black man was admitted to the Veterans Administration Research Hospital with complaints of facial pain, warm flushing, and numbness of the right leg. His past history included an absence of syphilis and no history of trauma to the chest or lower neck. He did not have complaints referable to his left arm or shoulder. Physical examination: blood pressure 140/90 in both arms. An asymptomatic pulsatile 2 x 3 cm mass was detected in the left supraclavicular region. There was no bruit over the mass. Neurological examination of both upper extremities was normal. With hyperabduction of the arms, the left radial pulse disappeared. The remainder of the peripheral pulse examination was normal. Laboratory values included a negative VDRL and a normal cholesterol level. The patient had an arterioautogram and a chest X-ray diagnostically.

Dr. John Beal: Why was he admitted?

Dr. Jack Swelstad: He complained of weight loss, a facial pain which was located below his eyes, worse on the right side, a feeling of warm flashes, and numbness extending up his right leg. He also had dysphagia. Gastrointestinal studies, including roentgenograms, were unremarkable. Otolaryngologic consultations could not find a cause for his facial pain.

Dr. Earl Nudelman: Initial chest X-ray was normal; the arterioautogram, including subtraction films, shows an aneurysm on the left subclavian artery. The aneurysm arises just beyond the thyro-cervical trunk. The other vessels which were visualized, including the carotid arteries, appear normal (Figure 1 & 2).

Dr. Jack Swelstad: The patient was taken to the operating room where he was explored through a left supraclavicular incision. After



Figure 1. Arteriogram demonstrated an aneurysm in the left subclavian artery.



Figure 2. Films, using subtraction technique, demonstrated the subclavian aneurysm more clearly.

division of the clavicular head of the sternocleidomastoid, the aneurysm was identified. When explored, it was found immediately distal to a tight, thickened anterior scalene muscle. It appeared to be poststenotic, secondary to muscle compression. The first rib was found immediately beneath the aneurysm but did not appear to contribute to the constriction of the subclavian artery.

The aneurysm measured approximately 2 x 3 cm. When opened, it appeared to have normal intima and was without mural thrombus. The aneurysm was resected and the proximal and distal ends of the vessel were easily approximated, permitting end-to-end anastomosis. A good pulse was felt in the radial artery and the patient had an uneventful postoperative course.

In regard to physical diagnosis, pulsatile masses in the lower neck and supraclavicular space are not uncommon and are not necessarily aneurysms. They generally represent tortuous arteries, either the carotid or subclavian, or sometimes a high riding aorta. Usually these lesions are asymptomatic and do not require treatment.

Generally speaking, peripheral artery aneurysms are uncommon. The most common sites involve the femoral and popliteal arteries. They almost always are arteriosclerotic in nature, associated with arterial wall breakdown. Subclavian artery aneurysms are rare. At one time, the proximal subclavian arteries were frequent sites of aneurysm formation secondary to syphilis; however, today the most common causes are arteriosclerosis, trauma (both penetrating and blunt injury), and thoracic outlet obstruction. Subclavian artery aneurysms usually are classified according to location, intrathoracic or extrathoracic. The present case is an example of an extrathoracic location. When spontaneous, as in this patient, they are almost always associated with cervical rib, some abnormality of the first thoracic rib, or a constricting anterior scalene muscle. Such aneurysmal dilatation is poststenotic and, as has been stated, the subclavian artery is the most common site of poststenotic aneurysm formation in the peripheral circulation. Dilatation is considered to be related to lateral vessel wall pressure, secondary to turbulent flow through the stenotic area.

When a peripheral aneurysm is detected or suspected by physical examination, the diagnosis is established by arteriography. Treatment is surgical. If a thoracic outlet syndrome is present and associated with mild poststenotic dilatation of the artery, removal of the cause of the stenosis, such as first rib or cervical rib resection, is adequate. However, when true aneurysmal dilatation of the artery is present, the basic principles of aneurysm treatment must be used. This involves exclusion of the aneurysm from the circulation and reestablishment of distal flow. That can be accomplished by either end-to-end anastomosis, or by vein graft or a dacron prosthesis.

The supraclavicular approach usually provides good exposure. Transaxillary approach may be considered when there are neurologic complications with thoracic outlet syndromes because the first rib can be resected. However, it would be difficult to perform aneurysmectomy and anastomosis through an axillary approach.

Dr. John Bergan: Dr. Swelstad has done a very nice job of emphasizing the importance of subclavian aneurysms. At this time, subclavian aneurysms are rare and today are almost always associated with cervical rib or thoracic outlet compression. This was not always true. Subclavian aneurysms in times past were very com-

mon and were caused by tertiary lues. In fact, Mattas invented the operation of endaneurysmorrhaphy when he, at the age of 28, first performed such a procedure on a subclavian aneurysm in the year 1888. Following that operation, which restored blood flow through this important artery, Halsted did some remarkable research on proximal ligation and aluminum banding of arteries in treatment of subclavian aneurysms.

There is a third great surgeon whose name is linked historically to subclavian aneurysms, Emile Holman. He proposed the theory of development of aneurysms distal to arterial stenoses. This theory applies particularly to subclavian aneurysms, since these lesions develop beyond first rib or cervical rib compression of the affected artery.

A significant contribution to the surgical literature regarding subclavian artery lesions came from this hospital. Ruge, Wetzel and Bell described a small group of patients in whom severe hand ischemia resulted from subclavian artery aneurysms and thoracic outlet compression of the subclavian artery.

Thus, subclavian aneurysms, though rare, were important in surgical history, and these points of history remind us of their devastating natural history and the pathophysiology of their development from proximal arterial stenoses. I suppose it would be fitting to close these comments with a reminder that the development of penicillin was the historically important medical factor that allowed eradication of syphilitic aneurysms of the subclavian artery.

Dr. Julius Conn, Jr.: We should remember that Bergan and Hoehn described the evanescent cervical pseudoaneurysm which is probably the most common cause for pulsatile masses in the base of the neck. These are usually found in slightly obese, hypertensive female patients. The pulsatile mass which feels like an aneurysm is actually a tortuous, dilated innominate subclavian or carotid artery. Careful palpation should delineate the tortuosity and rule out the presence of an aneurysm. In reviewing subclavian aneurysms associated with thoracic outlet neurovascular compression syndrome, vascular complications are present in less than 10% of the cases. Also, subclavian aneurysms are infrequent in the absence of a cervical rib. Most of those described have been associated with the cervical rib or some type of bony abnormality. Subclavian aneurysms associated with the thoracic outlet syndrome present with ischemia of the arms or hands are secondary to either emboli from the clot within the aneurysm or from thrombosis of the aneurysm.

Dr. Dennis Olson: Is an arterioautogram mandatory in the workup of a patient with a thoracic outlet syndrome?

Dr. Julius Conn, Jr.: We have not done routine arteriograms on these patients. We found the most helpful diagnostic test to be nerve conduction velocity studies. I think that if the patient has ischemia of the hands or claudication of the arms, then an arteriogram should be done. It should be a dynamic arteriogram with the patient in multiple positions, certainly with the shoulders hyperextended and arm abducted and externally rotated to see if there are changes in blood flow in different positions of the extremity. ◄

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2. Howell, J. F., Crawford, E. S., Morris, G. C., Jr., Garrett, H. E., and DeBakey, M. E.: "Surgical treatment of peripheral arteriosclerotic aneurysm." *Surg. Clin. North Am.* 46:979, 1966

Housestaff News

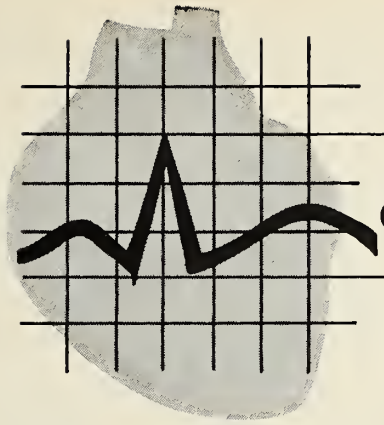
(Continued from page 263)

Occasionally, even the most astute clinician will make an error that results in patient suffering. This is regrettable, but physicians are human and we will make mistakes. However, the clinician who makes repeated mistakes needs to be re-evaluated. Post-graduate eduction is not the answer, inasmuch as these physicians may have already proven themselves uneducable. Rather, we need a system by which every physician's patient care is reviewed. If knowledge of current therapy is deficient, then it may be necessary to re-educate. If operative techniques are deficient, it may be necessary to limit that physician's operating privileges. If clinical judgement is poor, it may be necessary to limit that physician's patient contact.

These Orwellian methods sit uneasily with me, yet something must be done to protect the public against negligent and inept physicians. The public demands this protection and if the public is not satisfied, they will continue to seek the courts and congress for that protection.

The malpractice crisis is here, and there is reason to believe that we are to blame for it. We didn't intentionally cause it, and a large part of it we inherited, but we're stuck with it none the less. If we are foolish enough to trust the legal profession and governmental agencies to solve our problems for us, then we justly deserve whatever solutions they propose. Frankly, I would prefer that the medical profession meets the demands of the public. Let us provide a reasonable means of compensation for unfortunate victims of medical error. Let us find a means of protecting the public against our bad actors. If we can do this, our malpractice crisis will disappear. We can stop worrying about lawsuits and get back to taking care of patients.

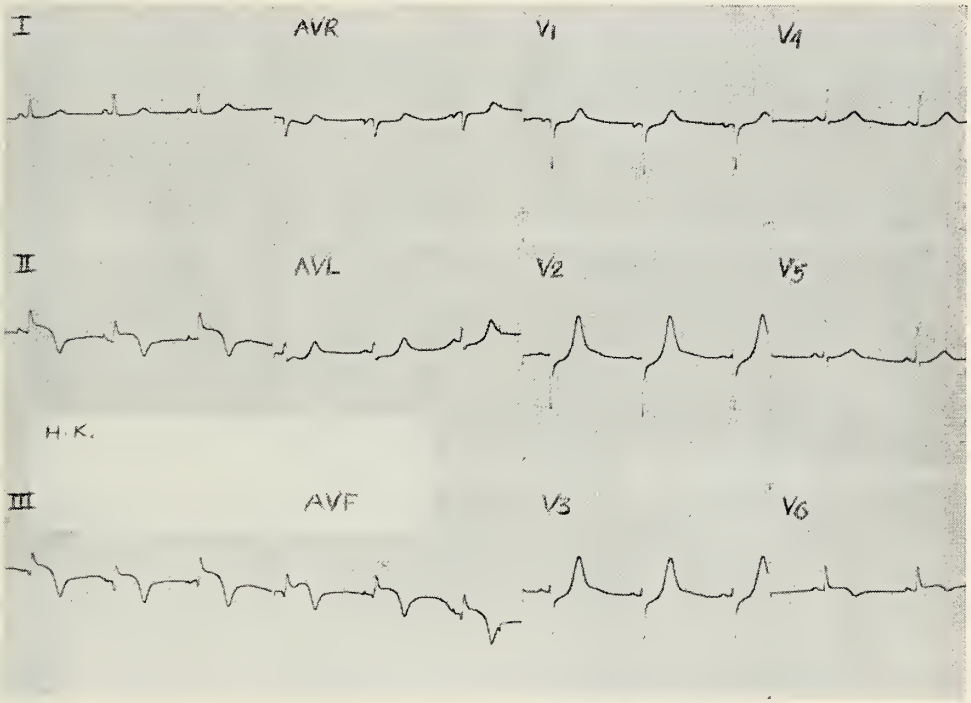
But then, that's just my opinion. ◄



ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

H. K., a 55-year-old housewife, was admitted to the hospital for control of myasthenia gravis. Symptoms improved gradually on pyridostigmine bromide (Mestinon) 240 mg every four hours and prednisone 70 mg daily. Fifteen days after admission patient complained of severe retrosternal pain. On examination she was found to be diaphoretic. Pulse was 48 and regular and the blood pressure was 90/60. Atropine 0.4 mg was given IV and patient was transferred to cardiac care unit.



Questions:

1. The electrocardiogram shows:

A. An acute inferolateral wall myocardial infarction.
B. ST-T segment changes secondary to hypercalcemia.
C. ST-T segment changes suggestive of an acute injury of the inferolateral wall.
D. Anteroseptal ischemia.
E. None of the above.

2. The clinical picture can best be explained by:

A. Prednisone induced esophagitis.
B. Evolving inferior wall myocardial infarction.
C. Pyridostigmine induced cardiac changes.
D. Cardiac abnormality secondary to myasthenia gravis.
E. None of the above.

(Answers on page 273)

Psychogenic Headaches with Mixed Anxiety and Depression

By Seymour Diamond, M.D./Chicago

A double-blind evaluation of combination therapy comparing perphenazine/amitryptyline and propoxyphene hydrochloride vs. placebo and propoxyphene hydrochloride in the treatment of psychogenic headache.

Approximately 90% of all headaches seen by general practitioners and internists are of the psychogenic variety. Individuals subject to depression or anxiety, or a mixture of both, are particularly vulnerable since such headaches usually encompass chronic recurring complaints associated with emotional problems. The remaining 10% of headaches are either of a vascular nature (8%) or due to organic disease or traction and inflammatory states (2%). The classification in Table 1 was established by the American Association for the Study of Headache and has been modified, as far as migraine is concerned, according to the World Federation of Neurology's Research Group which met in April, 1969.

TABLE I

Headache Classification

Traction & Inflammatory	Vascular	Psychogenic
Mass lesions	Migraine	Anxiety
	Classic	
Diseases of eyes, ear, nose, throat, teeth	Common	Depression
(Cranial neouralgias)	Cluster	Post-traumatic
	Facial	Muscle contraction
Allergy	Ophthalmoplegic	
Infection		
	Hemiplegic	
Arteritis		
	Toxic	
Temporomandibular joint dysfunction		
	Hypertensive	
Cervical osteoarthritis		
Chronic myositis		

Part of the symptomatology of headache either with anxiety or depression or a combination of the two is muscle contraction. Thus, what was once commonly termed muscle contraction headache should actually be called psychogenic headache. Since such large numbers (90%) of patients with psychogenic headache present an accompanying series of somatic, psychic or emotional symptoms, treatment with anti-depressant agents have proven useful.[1-3]

Purpose of Study

Purpose of the study was to assess the value of perphenazine/amitryptyline* 2/25 vs. placebo in office management of patients suffering from psychogenic headache. Only patients with moderate to severe muscle contraction as part of their mixed anxiety and depression were considered for the study.

A further attempt of the study was to determine whether effective treatment would decrease the amount of analgesic in the form of propoxyphene hydrochloride** necessary (frequency of need) for providing relief of the symptoms in these patients.

Specifically, the design of the study was a randomized double-blind study comparing perphenazine/amitryptyline 2/25 and propoxyphene hydrochloride 65 mg., *vs.* placebo and propoxyphene hydrochloride 65 mg., in the treatment of psychogenic headache. All subjects received one placebo dose unit three times a day for the initial week of the study. Those responding to one week of placebo therapy with marked to moderate improvement were eliminated from the double-blind phase.

The coded drug was to be administered in random sequence to 50 patients so that 25 received perphenazine/amitryptyline 2/25, 1 tablet, three times a day, plus propoxyphene hydrochloride 65 mg., q.i.d., prn. for headache;

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*Etrafon® (brand of perphenazine/amitryptyline hydrochloride) Schering Corporation, Bloomfield, New Jersey.

**Darvon® (brand of propoxyphene hydrochoride) Eli Lilly and Company, Indianapolis, Indiana.

and 25 received placebo, 1 tablet, t.i.d., plus propoxyphene hydrochloride 65 mg., prn. for headache. At every visit, each patient provided a record of the date of each dose of analgesic taken. No other medication for the treatment of anxiety, depression or headache were used during the period of the study. All concomitant therapy for other physical disorders were held constant throughout the trial or the case was eliminated.

Criteria for the investigator's evaluation of the response to treatment was as follows:

1) Marked Improvement—Complete or nearly complete remission of symptoms.
2) Moderate Improvement—Partial remission of symptoms with favorable alteration of the status of patient care.
3) Slight Improvement—Subtle remission of symptoms without alteration of the status of patient care.
4) No Improvement—Condition unchanged.
5) Worse—Condition deteriorated.

The patients were seen at the initial visit and one week later for the second visit. The third, fourth, and fifth visits were at two week intervals.

These evaluations were made by the investigator at the second, third, fourth and final visits. An overall evaluation of treatment also was made at the final visit.

Self-evaluation by the patient was determined at the second, third, fourth and final visits, and an overall evaluation at the final visit.

TABLE II
Perphenazine/Amitryptyline 2/25 vs. Placebo Study
Treatment by sex and age

	Perphenazine/Amitryptyline 2/25		
	No. Pts.	Average Age	Age Range
Females	14	39.1	22-64
Males	8	35.5	24-57
TOTALS	22	37.8	22-64
	Placebo		
	No. Pts.	Average Age	Age Range
Females	18	44.3	21-62
Males	6	38.3	21-56
TOTALS	24	42.8	21-62

Results

The primary diagnosis of all patients for the purpose of this evaluation was psychogenic headache with mixed anxiety and depression of at least moderate severity.

Fifty-two patients of the double-blind phase of the study initiated after visit 2 were randomly assigned to one of the two treatment groups. There were 26 patients on the perphenazine/amitryptyline group and 26 patients on the placebo group. Fourteen males and 32 females completed the study. Twenty-two received perphenazine/amitryptyline and 24 placebo.

The perphenazine/amitryptyline 2/25 group statistically showed more favorable results than placebo group for at least one post-treatment visit for the primary target symptoms of anxiety and depression, and for the psychosomatic symptoms of concern, overactive, abasement or somatic concern. Statistical significance also was shown at all post-treatment visits with results favoring the perphenazine/amitryptyline group for both the physician and patient's overall evaluation of drug effect.

TABLE III
Investigator's Overall Evaluation of Treatment

	Marked Improvement	Moderate Improvement	Slight Improvement	No Improvement	Worse
Perphenazine/ Amitrypty-line	10	6	1	4	1
Placebo	5	4	1	13	1

For the average number of propoxyphene hydrochloride tablets required per day for the double-blind phase of the study, no significant difference was found between treatment groups at the final visit.

With respect to side effects, the perphenazine/amitryptyline 2/25 group reported more statistically significant not unexpected side effects than the placebo group at visit 4 only. The expected side effects of sedation and drowsiness were the major complaint.

Since there was no difference in the consumption of propoxyphene hydrochloride either with the placebo group or the perphenazine/amitryptyline group it may indicate that a study of analgesics may not be a true measure for degree of anxiety or depression relief, or the combination of the two.

In this double-blind, comparative study, perphenazine/amitryptyline produced significantly better results in the treatment of patients with psychogenic headache and anxiety/depression of moderate severity. ◄

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Training of Emergency Medical Technicians—Ambulance

By Clarence R. Hart, M.D., and James T. O'Heir/McHenry

The Committee on Emergency Medical Services of the National Academy of Science-National Research Council now considers definitive life support at the scene of any emergency as a necessary community service and strongly urges the health professions and concerned public and private agencies to support its immediate adoption as an appropriate national goal.[1]

In a survey to evaluate prehospital emergency care in the city of Pittsburgh, it was revealed that only 38% of the urgent and critically ill patients were adequately managed enroute to the hospital.[2] It is likely that the greatest number of preventable deaths occur before the patient ever gets to a treatment facility, many of these from untreated shock. It is no longer defensible to state that medical care and concern begin at the hospital door. It begins when and where the patient is injured and first seen.

The system used for treating combat casualities in Viet Nam, as suggested in the Management of Trauma,[3] is now being duplicated in the United States, in particular in Illinois. There are obvious elements of communications, transportation and regionalization which are being developed. In Illinois, the trauma systems devised by the Department of Public Health, Division of Emergency Medical Services and Highway Safety, is duplicating the major components of the military system.[4] The statewide trauma system is a systematic approach to the delivery of emergency medical care. The total system does involve appropriate communications and organization at each level, and requires planning, education, self-evaluation and research in systems management to be maximally effective.

In-hospital treatment of emergencies must be built on an adequate and comprehensive prehospital emergency care system. As estimated in autopsy studies, with prompt and effective emergency medical care, approximately 20% of crash victims who were dead on arrival might have been saved.[5] A drop of 24% mortality of those injured in a Jacksonville, Fla., study confirms the estimates in actual practice.[6]

In the State of Illinois, results are now being seen. According to the National Highway Safety statistics, there was an 8% decrease in the death rate of highway related accidents in 1972. At the present time, under the Critical Care Fellowship Program of the Department of Public Health, we are studying the effectiveness of training and on-site activities of local emergency medical prehospital systems. In order to accomplish this, we are approaching the problem in three ways:

1. We are looking at the motivation, composition, administration and economics of these volunteer rescue organizations.
2. A portion of the study has been designed to evaluate the effectiveness of the EMT-A training programs as sponsored by the Department of Public Health and the Department of Transportation of the State of Illinois and offered through McHenry County College.
3. We are studying the prehospital care given at the scene through progressional evaluation in the emergency room.

CLARENCE R. HART, M.D., McHenry, is Director of the Trauma Center and attending orthopedic surgeon at McHenry Hospital. Dr. Hart is also President of the American Trauma Society, State of Illinois Division.





JAMES T. O'HEIR, is Emergency Medical Services Coordinator for McHenry County.

Ambulance Service

In McHenry County there are approximately 400 members of the ambulance services, all volunteers. In addition to these personnel, actively engaged in ambulance services are members of the sheriff's police and county civil defense. These have participated in the training program in order to enhance their expertise.

Prehospital care required for the critically ill or injured patient in the county is covered by 14 ambulance units, all of which have enrolled individuals in the EMT-A courses conducted at the Trauma Center. One of the 14 units is a private ambulance operation which is capable of not only emergency response but also will handle rountine transfer of patients throughout the medical system. This unit is used widely in those places where the helicopter is not indicated. Other units operating in the county are either affiliated with fire departments or are totally independent volunteer units chartered on a not-for-profit basis. Eleven of these units levy no charge for emergency ambulance service. Of the emergency medical capability of the county, 98% is provided by volunteer rescue units. (Table 1)

TABLE I

Ambulance Services

Type	Number	Business	Free of Charge	Flat Fee
Independent	8		8	
Municipal	1			1
Fire Department	4		4*	
Private Corp.	1	1		

***One unit has tax support as result of recent referendum.**

In any community where service is provided primarily by volunteer rescue ambulance units, it was thought desirable to examine in some detail the motivation, composition and economics of these rather unique organizations. It is apparent there is minimal cost to consumers.

A questionnaire was sent to all volunteer units in the McHenry County, Western Lake County area to determine the pattern, history and economics of the units. It was felt this could provide base data as to the cost, motivation, and organization, and give clues to possible expansion to statewide application.

It must be pointed out that the County of McHenry has three acute care medical facilities. These three hospitals are located in Harvard, Woodstock, and McHenry. All cooperated in this research project.

A survey of these units revealed an average cost per year of $5,400 to maintain and replace existing equipment, or to purchase newer or more modern equipment. This does not reflect expenses involved in the purchase of new vehicles, nor the start-up expenses connected with the establishment of a new unit. These costs have been defrayed in all cases of volunteer units by fund drives organized by the members of the unit, and by contributions from various community service organizations, as well as from the citizens of the community.

Personnel of the units gave the following reasons for becoming active in this endeavor:

1. The desire to serve the community, was most prevalent.
2. Became members through contact and association with family members or friends active in these organizations.
3. Past personally beneficial experience encouraged joining to provide similar service to others.

Emergency Medical Technician-Ambulance Training Program Evaluation

Any evauation of the effectiveness of the EMT-A Program, should include a demonstration of the level of knowledge possessed by class members prior to training, and a measurement of the effectiveness of subsequent training. All active members of the units in McHenry County and Western Lake County have had training based on the advanced first aid course of the American Red Cross. To determine the effectiveness of the Dunlap Course taught under the trauma program, special examinations have been administered to three consecutive classes.[7]

All personnel attending training in McHenry County also take the test sponsored by the National Registry of EMT-A in Columbus, Ohio.

The course used to prepare the personnel for the Registry test is an 82 hour course designed through the cooperation of the American Academy of Orthopedic Surgeons.[7] It is designed to augment knowledge previously gained through a standard and advanced first aid training. The unique feature of this course is the requirement that all students spend a minimum of 10 hours in the emergency room under the supervision of medical professionals. There are 24 segments, the majority of which are taught by physicians, with the local E.M.S. Coordinator as an assistant. A great portion of time is spent insuring that all students are above average in performance of cardiopulmonary resuscitation. Classes are held in extrication of injured from vehicles, the proper operation of an ambulance and the correct

method of response to an emergency call by an ambulance crew.

The local trauma center personnel have devised a separate 91 question, 134 answer test. This is designed to evaluate the course and its effectiveness and serve to produce an "attitude of learning" on the part of candidates. The test is administered twice to each class. There has been an almost universal and significant improvement in the test scores after the course has been completed. The national failure rate on EMT-A Registry examination is 28%, and the McHenry County failure rate is 18%.

Ambulance Incident Reports and E.R. Evaluation Reports

In an attempt to determine adequacy of prehospital emergency care provided by ambulance services of McHenry County, personnel of the local trauma center designed an ambulance report which was utilized with the cooperation of the majority of the volunteer and private ambulance services in the county. The report was designed to be as brief as possible and yet capable of providing a true picture of the incident, the ambulance attendants' evaluation of the nature and extent of the illness or injury, and a report of the treatment rendered by the attendant. It also indicates whether the ambulance attendant has been certified. The ambulance incident check sheet serves a further function of preparing the EMT-A to make rapid evaluations in order to categorize patients, according to a critical injury index, in the prehospital evaluation of the patient.

The report summary covers the period July 1, 1973, through June 30, 1974, and includes reports submitted by 10 ambulance units, both volunteer and private. This does not reflect total ambulance calls throughout the county since several of the units declined to participate in the evaluation process. However, all cases in which there was possible mismanagement of the patient have been included in the study. In those latter cases, the ambulance incident report was provided by the emergency room and an emergency room professional evaluation was appended.

TABLE II

Type of Incident	Number
Injury (Except vehicular or due to violence)	215
Illness (Except cardiac)	143
Cardiac	93
Vehicle related injury	231
Violence	13
Childbirth-miscarriage	2
Self-inflicted illness or injury	18
Dead on arrival (at scene)	17
Dead on arrival (at hospital)	7
TOTAL	739

TABLE III

Training Level of Personnel Responding to Incidents		
EMT-A	Non-EMT-A	Total
579	160	739

Criticism Index		
Personnel	Incidents	Per cent
EMT-A	3	0.005%
Non-EMT-A	13	0.081%

The Citicism Index is considered statistically significant.[8]

There were a total of 739 reported cases, of which 579 were handled by ambulance crews on which at least one member was certified. In the EMT-A handled incidents, three critical comments were submitted by the emergency room personnel. One of the comments related to improper information regarding the patient being transmitted on the radio to a third party in the emergency room while the patient was enroute in the ambulance. The other related to a lack of use of any airway for a young child who had been submerged in a cave-in. It was found that the child's oral pharynx was tightly packed with dirt for a long period of time prior to extrication and transportation. Resuscitation would have been fruitless. The third incident was a case ultimately diagnosed as hyperventilation syndrome in which the patient was ventilated unnecessarily.

Of the 160 incidents in which no EMT-A was involved, 13 adverse comments were submitted.

Criticism of the type described above depend on subjective evaluation by the medical person in the emergency room. In a case of proper immobilization, traction apparatus had been applied but was felt to be too loose and ineffective. The patient subsequently did well. In an evisceration case, dressings had been applied but no supporting bandage had been applied over this. The evisceration proceeded and continued until a great portion of the intra-abdominal bowel content presented outside the abdominal cavity. This patient subsequently also did well. At no time in the study has there been any evidence of long term morbidity resulting from mismanagement of structural injury in the prehospital situation. In all seven incidents of lack of cardiopulmonary resuscitation, the patients were dead on arrival at the emergency room. Statistics have shown that cardiopulmonary resuscitation can be effective in increasing the salvage rate of the cardiac patients[2] and possibly some criticism is valid at this point. The decision of whether to institute cardiopul-

monary resuscitation is difficult at best. Incidents regarding poor patient concern involved asthmatic patients who were made to rise from a low ambulance cot to the emergency room cart over verbalized objections of the emergency personnel. (See Tables)

TABLE IV

Adverse Comments	Number
EMT-A	
No airway (cave in)	1
Improper radio information	1
Unnecessary ventilation	1
Non-EMT-A	
Improper immobilization (femur)	2
Ineffective dressing and bandage (evisceration)	2
Non cardio-pulmonary resuscitation	7
Poor patient concern	2
Unnecessary tourniquet	1

Discussion

Based on statistics shown in the followup of the reported incidents, prehospital care given has been outstanding. This is a tribute to the Rescue Squad, the EMT-A training program, and the adherence of organizations to the National Safety Council recommendations on types of transporting vehicles and equipment and their use.

Rural communities are not merely miniaturized versions of cities and suburbs and they do require different approaches to emergency care than are relevant to urban areas. Emphasis should be placed first on improving capabilities to respond to emergencies of life and limb, rather than responding to the much larger number of less serious events where inadequate care would result in inconvenience only. Most persons who die unnecessarily could be saved with relatively simple techniques.[2]

Continued improvement of basic service and skills is much more important than is development of highly sophisticated training programs and response systems. Standard protocols for emergency response, for both hospital and ambulance personnel, need frequent critique sessions.

Program evaluation has to be an integral part of any improvement effort. In our evaluation one can demonstrate continued improvement of this country's response capability. Finally, in order to train and evaluate personnel as compeletely as possible, a countrywide disaster exercise was planned and has been performed and critiqued for the benefit of all. Some of the lessons to be learned in this county may be of value to other areas in dealing with their own environment ◄

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EKG

(Continued from page 267)

Answers: 1. C 2. B

Acute injury current is seen in the inferolateral wall leads. Small Q's are seen in II and AVF. Larger Q in III is difficult to interpret on a single tracing. Q wave to be pathologic should be at least 0.04 seconds in duration or >25% of the QRS complex. Appearance of smaller new Q waves may suggest myocardial infarction.

Serial studies revealed appearance of pathologic Q waves in II and AVF and diagnostic serum enzyme changes. ST-T segment changes have been reported in patients with myasthenia gravis. These have included ST depression and flattening of T waves. Neostigmine has been shown to normalize some of these. Goodman and Gilman have reported that neostigmine may increase amplitude of T waves in normal individuals. Patients with myasthenia have been reported to have retrosternal pain, palpitations, and increased incidence of sudden death. At autopsy myocardial lesions are not uncommonly found. Although our patient's cause of infarct was probably coronary artery disease, cardiac involvement in myasthenia gravis should be considered especially in the young individuals. ◄

Request for Medicare Fee Data

Physicians in Illinois who wish to determine their fee profiles, based on Medicare billings, may make inquiry utilizing the following form and addressing it as indicated below.

Physician Request for Medicare Fee Data*

☐ Please send my individual fee profile data.

☐ Please send the area prevailing fee for the procedures listed in my profile.

I understand there is no charge for the first 10 pages of the information requested above. There is a ten cent (10¢) per page copying charge for each additional page.

*I understand the fees listed in my profile represent either the median of my charges submitted in the previous fiscal year, or the area prevailing fee—whichever is lower.

Thank you.

_____, M.D.

(address)

(city) (state) (ZIP)

Medicare provider number: _____

(cut here and send above to:)

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Blue Cross/Blue Shield
P.O. Box 2218
Chicago, Ill. 60690
Attention: Provider Update Unit

other than Cook County—
Medicare
Continental Casualty Company
P.O. Box 910
Chicago, Ill. 60690

At its recent meeting, the ISMS Board of Trustees reaffirmed previous action regarding physician billing to insurance carriers.

Physicians again are urged to utilize the AMA standard insurance claim form, as depicted on the facing page, for all billings to insurance carriers. If a carrier insists that its own form be completed, ISMS members are encouraged to charge for this service. ISMS already has informed the Health Insurance Association of America of the Board's actions, and has asked HIAA to convey this information to all its members carriers.

The Board also encourages all ISMS members to use AMA's *Current Procedural Terminology*—Third Edition, for all coding and terminology on third party claims. The Board is convinced that a concerted effort by the membership will force carriers to accept the standard claim form and coding procedure, thus expediting claims processing.

Physicians can purchase quantities of the standard claim form by using the order form below.

Order Blank
Health Insurance Claim Form

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American Medical Association
535 North Dearborn
Chicago, Illinois 60610
(312) 751-6000

Type of form		Quantity—in orders of:		Price Including Handling and Postage
☐ Single Form (One page pads of a hundred)	OP-407	1,000	☐	$ 18.50
		5,000	☐	78.00
		10,000	☐	138.00
☐ Two Forms (Original and one carbon)	OP-408	1,000	☐	28.00
		5,000	☐	112.00
		10,000	☐	210.00
☐ Continuous Form (Original and one carbon) (For Computer Printers)	OP-409	1,000	☐	28.00
		5,000	☐	112.00
		10,000	☐	210.00

TOTAL _____

CHECK ☐ Enclosed MONEY ORDER ☐ Enclosed

Type or Print

Name_____

Street Address_____

City_____ State_____ Zip_____

Check or money order must accompany this order and be made payable to the American Medical Association.

NOTE: Larger quantities available at special rates. Call or write the American Medical Association.

HEALTH INSURANCE CLAIM FORM

Read instructions on back before completing form

TYPE OR PRINT ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. Patient's name *(First name, middle initial, last name)*	2. Patient's sex ☐ Male ☐ Female	3. Insured's Identifying No. *(Include any letters)*
4. Patient's address *(Street, city, state, ZIP code)*		5. Insured's Group No. *(or Group Name)*

6. If patient has other health insurance, health plan or state assistance, enter its Name, Address and Policy or Medical Assistance Number

7. Was illness or injury connected with patient's employment?	☐ No	☐ Yes	☐ Unknown
8. Patient's or authorized person's signature *(Read back before signing)* I authorize the release of any medical information necessary to process this claim. SIGNED		9. Date signed	10. Patient's date of birth
11. Patient's relationship to insured:	☐ Self	☐ Spouse	☐ Child ☐ Other
12. Insured's **name** *(First name, middle initial, last name)* **Address** *(Street, city, state, ZIP code)*		13. I authorize payment of medical benefits to undersigned physician or supplier for service described below. **SIGNED** *(Insured or Authorized Person)*	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE ILLNESS / INJURY / PREGNANCY — DATE OF FIRST SYMPTOMS / DATE OF ACCIDENT / DATE OF LMP	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ NO ☐ YES
17. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	18. DATES OF PATIENT'S DISABILITY — TOTAL DISABILITY FROM DATE / THROUGH DATE	PARTIAL DISABILITY FROM DATE / THROUGH DATE
19. NAME OF REFERRING PHYSICIAN	20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES	DATE ADMITTED / DATE DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

22. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1, 2, 3, ETC. IN COLUMN D)

1.
2.
3.

23. A DATE OF EACH SERVICE	B PLACE OF SERVICE *See codes below	C DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES) PROCEDURE CODE	D DX NO.	E CHARGES *(Explain unusual circumstances in Column C)*	F LEAVE BLANK

24. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.	25. SOCIAL SECURITY NO.	28. TOTAL CHARGES
	26. EMPLOYER I.D. NO.	29. AMOUNT PAID
	27. OTHER IDENTIFYING NO.	30. BALANCE DUE

31. ACCEPT ASSIGNMENT *(See back)* ☐ YES ☐ NO	32. SIGNATURE OF PHYSICIAN OR SUPPLIER *(Read back before signing)* SIGN HERE	33. DATE SIGNED	34. YOUR PATIENT S ACCOUNT NO.

*PLACE OF SERVICE CODES

1–(IH) – INPATIENT HOSPITAL
2–(OH) – OUTPATIENT HOSPITAL
3–(O) – DOCTOR'S OFFICE
4–(H) – PATIENT'S HOME
5– DAY CARE FACILITY (PSY)
6– NIGHT CARE FACILITY (PSY)
7–(NH) – NURSING HOME
8–(SNF) – SKILLED NURSING FACILITY
9– AMBULANCE
O–(OL) – OTHER LOCATIONS
A–(IL) – INDEPENDENT LABORATORY
B– OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 10-73

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SPECIALTY REVIEW IN DERMATOLOGY, May 5
SPECIALTY REVIEW IN PEDIATRICS, April 7
SPECIALTY REVIEW IN MEDICINE, CERTIFYING, May 11 & June 1
SURGERY OF GASTROINTESTINAL TRACT, One Week, April 7
BLOOD VESSEL SURGERY, One Week, April 14
ADVANCES IN SURGERY, One Week, May 12
BASIC INTERNAL MEDICINE, One Week, March 17
FAMILY PRACTICE REVIEW, One Week, April 7
ADVANCES IN MEDICINE, One Week, April 21
INTERMEDIATE EKG, Two Days, May 8
ADVANCED CARDIOLOGY, One Week, May 19
NEUROLOGY, PART I, BASIC, March 17
NORMAL DEVELOPMENT IN CHILDHOOD & ADOLESCENCE, April 28
DIAGNOSTIC RADIOLOGY, One Week, April 14
ADVANCES IN NEONATOLOGY, Two Days, April 21
BASIC GYNECOLOGY, One Week, April 14
STATE & NATIONAL BOARD REVIEW, Basic & Clinical, April 27 and May 5

Information concerning numerous other continuation courses available upon request.

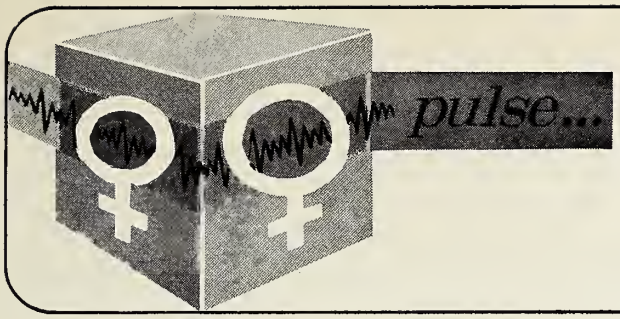
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pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

Bicentennial Committee

Illinois is commemorating the 200th anniversary of the United States and the Bicentennial of the American Revolution. Our Auxiliary is invited to cooperate by planning programs reflecting the last two hundred years of our history.

Our Bicentennial Committee; Mrs. Joseph Shanks, *Chairman,* Mrs. Robert Hartman, and Mrs. August Marticucci; has chosen as its *Heritage Project* **WOMEN IN MEDICINE IN ILLINOIS 1776-1976**

Nominating Committee Presents

The Nominating Committee; Mrs. Robert R. Hartman, *Chairman,* Mrs. Eugene Pitts, Mrs. P. W. Sawyer, Mrs. Joseph Shanks, and Mrs. Newton DuPuy; presented the slate of officers for 1975-76 at the winter board meeting. Presented were:

PRESIDENT Mrs. Eugene Vickery

PRESIDENT-ELECT Mrs. John Ovitz, Jr.

VICE-PRESIDENT (Membership) Mrs. Ralph Davis

VICE-PRESIDENT (Program) Mrs. Earl Klaren

VICE-PRESIDENT (Community Health) Mrs. Edward Szewczyk

TREASURER Mrs. Harlan Failor

RECORDING SECRETARY Mrs. William Hodges

DIRECTORS Mrs. Thomas Glatter
Mrs. Leo Kempton
Mrs. Paul David

The election will be held at the State Convention in Chicago on Wednesday, April 2, 1975.

NOTE: The luncheons to be held during the State Convention in April will be in two different locations.

Wednesday, April 2—**Presidents Luncheon**—Furniture Club of America Fashion Show by Saks Fifth Ave.

Thursday, April 3— **Installation Luncheon**—John Hancock Building; 95th floor, Waa-Mu Performers from Northwestern University

Buses will be available for transportation to and from the luncheons. The bus will leave at 12:15 P.M. for the 12:30 P.M. luncheon and return at 3:30 P.M.

IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

Gonorrhea, according to the national Center for Disease Control, is, if the parenteral route is chosen, most effectively treated with aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

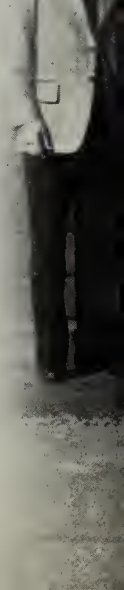
Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis., Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?



On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population.* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IN SYPHILIS
INJECTION
Bicillin® LONG-ACTING
(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

For deep intramuscular injection only.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

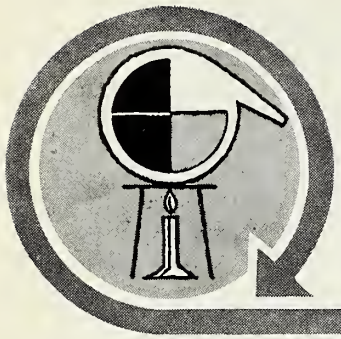
(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: Units benzathine penicillin G (as active ingredient): 2,400,000 units in 4-cc. single dose disposable syringe. Each disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben, and 0.01% propylparaben. 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. povidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101
™



*U.S. Dept. of Health, Education, and Welfare: VD Fact Sheet 1972. Publication No. (HSM) 73-8195.



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Products—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

COMBINATION PRODUCTS

BREVICON — Oral Contraceptive Rx

Manufacturer:	Syntex Laboratories, Inc.
Composition:	Norethindrone 0.5 mg. Ethinyl estradiol 0.035 mg.
Indications:	Oral contraception
Contraindications:	Those commonly applying to this type of drugs.
Dosage:	One tablet daily from the fifth through 25th day of the menstrual cycle.
Supplied:	Tablets, 21 per dispenser.

SENECOT S — Laxative o.t.c.

Manufacturer:	Purdue Frederick Company
*Composition:	Senna Concentrate Diocytyl Sodium Sulfosuccinate
Indications:	Functional and other forms of constipation.
Dosage:	Given at bedtime Adults, 2 tablets (maximum—4 tablets) Children, above 60 lbs, 1 tablet.
Supplied:	Tablets

*Exact composition given by manufacturer.

NEW DOSAGE FORMS

VAGITROL Suppositories — Sulfonamide Rx

Manufacturer:	Syntex Laboratories
Composition:	Sulfanilamide 1.05 Gm. Aminacrine HCl 0.014 Gm. Allantoin 0.14 Gm.
Indications:	Infectious diseases of the vagina.
Contraindications:	Renal diseases
Dosage:	1 suppository intravaginally once or twice daily.
Supplied:	Suppositories

ZIPAN — Antihistamine Rx

Manufacturer:	Savage Laboratories
Nonproprietary Name:	Promethazine HCl
Indications:	Symptoms caused by allergic disorders. Preoperative medication, motion sickness, nausea.
Contraindications:	Comatose states, asthmatic attacks, glaucoma and other conditions listed in package insert.
Dosage:	Refer to package insert.
Supplied:	Syrup 5 cc/12.5 mg.

Medcoa CORPORATION *Proudly Presents*

THE SECOND BUILDING
IN ITS
MEDICAL OFFICE COMPLEX

in the heart of Schaumburg-Hoffman Estates, the most rapidly growing residential area in the United States. 250 car on-site parking.

FIVE FLOORS — CUSTOM SUITES — ALL ELECTRIC — FULL SERVICE
PHARMACY — RADIOLOGY-NUCLEAR MEDICINE — CLINICAL LABORATORY

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5653 N. Ashland, Chicago, Illinois 271-0123

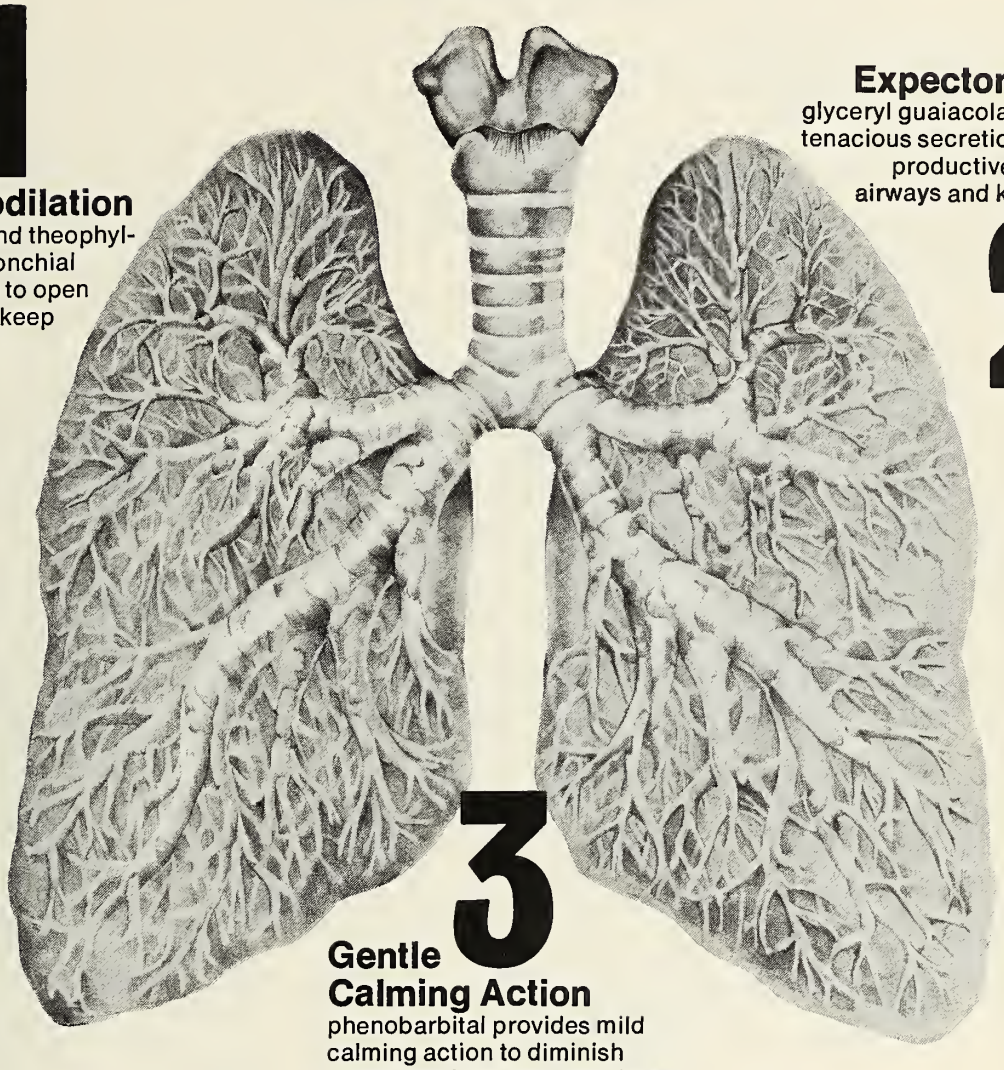
In the treatment of the asthma complex consider the advantages of BRONKOTABS®

1

Potent Bronchodilation
ephedrine and theophylline relax bronchial musculature to open airways and keep them open.

Efficient Expectorant Action
glyceryl guaiacolate helps liquefy tenacious secretions and enables productive cough to clear airways and keep them clear.

2



3

Gentle Calming Action
phenobarbital provides mild calming action to diminish hyperreactions that can trigger bronchospasm.

PRECAUTIONS AND ADVERSE EFFECTS: Sympathomimetic side effects are minimal, and there are none of the dangers or side effects associated with steroid therapy. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Should be used with caution in the presence of hypertension, heart disease or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

DOSAGE: Adults, one tablet every three or four hours, four or five times daily. Children over six, one-half the adult dose. Children under six, as directed.

SUPPLIED: Bottles of 100 and 1,000 tablets.

BREON

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

to treat the individual– not an individual symptom

BRONKOTABS®

Each tablet contains ephedrine sulfate 24 mg; glyceryl guaiacolate 100 mg; theophylline 100 mg; phanoberbital 8 mg (warning: may be habit-forming).

ISMS Guide to Continuing Medical Education

Compiled for Illinois physicians by the
ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION
55 E. Monroe St., Suite 3510 • Chicago, IL 60603 • (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

April, 1975

Aging

AGING 1975: MYTHS AND REALITIES
For: Professionals serving the aging, 2-day Community Conference, Apr. 10-11, 9:00 AM—5:00 PM, Sheraton-Chicago, Chgo. **Fee:** $50. **Sponsor, contact:** Ill. Assoc. of Homes for the Aging, 3300 W. Peterson Ave., Chgo. 60659.

Basic Sciences

STATE AND NATIONAL BOARD REVIEW COURSE, BASIC
For: All MDs. 6½ day-Course, Apr. 27-May 3, Chgo. **CME Credit:** 58 hrs., AMA Cat. 1. **Fee:** $225. **Limit:** 85. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Cancer

AGRESSIVE TREATMENT OF CANCER: REWARD AND RISKS
For: MDs. 2nd Wed. of Mo., Apr. 9, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

BREAST CARCINOMA
For: All MDs. Short Course, Apr. 23, Gary. **CME Credit:** 6 hrs., AMA Cat. 1, AAFP. **Fee:** $35. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U. Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

Cardiology

HEART DISEASE 1975
For: GPs, Interns, RNs. 2-Day Wkshp., Apr. 18-19, Giant City State Park Lodge, Makanda, IL. **CME Credit:** 6 hrs., AAFP Applied for. **Fee:** $30 MDs, $15 RNs. **Sponsor, contact:** IL. Heart Assoc., Professional Ed. Council, 1007 W. Mill St., P.O. Box 3496. Carbondale, IL 62901.

Clinical Practice

COMMON LEGAL PROBLEMS IN CLINICAL PRACTICE
For: MDs & Nurses. Lecture, Apr. 16, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Family Medicine

BASIC GYNECOLOGY
For: All MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Family Practice Therapy

WORKING WITH PROBLEM FAMILIES
For: Family Physicians & Family Therapists. 2-Day Seminar, Apr. 25-26, Holiday Inn, Oak Brook Terrace, Villa Park, IL. **CME Credit:** 11 hrs, AAFP Elective. **Fee:** $75. **Sponsor, contact:** Family Practice Cntr., MacNeal Memorial Hosp., 3249 S. Oak Park Ave., Berwyn, IL 60402.

General Interest

"PRACTITIONERS & PROFESSORS: PARTNERS IN CME"—3rd ILLINOIS CONGRESS ON CME
For: All interested in CME. Conference/workshop, Apr. 18-19, Chateau Louise, Dundee, IL. **CME Credit:** 9 hrs., AMA Cat. 1. **Fee:** $35. **Limit:** 100. **Sponsor, contact:** IL Council on CME, 55 E. Monroe St., Suite 3510, Chgo. 60603.

INFECTIOUS DISEASES
For: MDs, Discussion/Lecture/Discussion, Apr. 11: Belmont Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood, 6:00 PM; Apr. 12: American Hosp., Chgo., 10:00 AM. **CME Credit:** 5 hrs., AMA Cat. 1, AAFP. **Fee:** $10. **Sponsor, contact:** J. McCracken, Belmont Hosp., 4058 W. Melrose St., Chgo. 60641.

Immunology

IMMUNOLOGY
For: All MDs. Course, April 30, 8:00 AM, Melrose Pk, IL. **CME Credit:** 8 hrs., AMA Cat. 2. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp., 1225 Superior St., Melrose Park, IL 60160.

Internal Medicine

FAMILY PRACTICE REVIEW
For: All MDs. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

ADVANCES IN MEDICINE
For: Internists. 5-day Course, Apr 28-May 2, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Neurosurgery

DIAGNOSIS OF A BRAIN TUMOR
For: MDs & Nurses. Lecture, Apr. 30, 11:00 am, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, AAFP Prescribed. **Speaker:** L. Yarzagaray, MD, Asst. Prof/Neurosurgery, Loyola U. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir./Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Ob-Gyn

THE NEW AND OLD IN OB-GYN
For: MDs, 1-day Symposium, Apr. 16, 8:30—5:00, Belleville, IL. **CME Credit:** 6 hrs., AMA Cat. 1. **Fee:** $15. **Sponsor, contact:** H. Lange, MD, Med. Dir., St. Elizabeth's Hosp., 211 S. Third St., Belleville, IL 62221.

Pediatrics

ADVANCES IN NEONATOLOGY
For: Pediatricans. 2-day Course, Apr. 21-22, Chgo. **Fee:** $75. Sponsor, contact: Ck. Cnty. Grad. Sch./Med, 707 S. Wood St., Chgo. 60612.

RESIDENTS' COMPETITION
For: Pediatricians. Monthly Mtg., Apr. 22, Social Hr.—6:00 pm., Dinner—7:00 pm, Program— 8:00 pm, Mercy Hosp. & Med. Cntr., Chgo. **Fee** Dinner $12/ea. **Sponsor:** Chgo Pediatric Society, **Contact:** L. M. Zollar, MD, 7141 S. Jeffery, Chgo. 60649.

SPECIALTY REVIEW COURSE IN PEDIATRICS
For: Pediatricians. 5½-day Course, Apr. 7-12, Chgo. **CME Credit:** 38 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Psychiatry

CHILD AND ADOLESCENT NORMAL DEVELOPMENT AND BEHAVIOR PROBLEMS
For: MDs. 5-day Course, Apr. 28-May 2, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

MANIC-DEPRESSIVE ILLNESS: HISTORY OF A SYNDROME
For: Psychiatrists. Wkly. Seminar, Apr. 2, 9, 16, 23, 30,/5:00-6:30 pm. Chgo. **CME Credit** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601

PSYCHOANALYTIC PSYCHOLOY
For: Psychiatrists. Wkly. Seminar, Apr. 7, 14, 21, 28./6:30-8:00 pm. Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125 **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Mich. Ave., Chgo. 60601.

THE RELATIONSHIP OF THEORY TO THE CLINICAL PRACTICE OF PSYCHOTHERAPY
For: Psychiatrists. Wkly. Seminar, Apr. 3, 10, 17, 24, 6:30-8:00 pm, Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** Inst. for Psychoanalysis, Continuing Ed. Prog., 180 N. Michigan Ave., Chgo. 60601.

CLINICAL ASPECTS OF DELINQUENCY AND CRIMINALITY
For: Psychiatrists. Wkly. Seminar, April 3-June 5, 8:00-9:30 AM, Chgo. **CME Credit:** 15 hrs., AMA Cat. 1. **Fee:** $125. **Sponsor, contact:** J. Pelombo, Co-Chmn., Cont. Ed. Comm., Inst./Psychoanalysis, Cont. Ed. Prog., 180 N. Mich. Ave., Chgo. 60601.

Radiology

CHEST RADIOLOY
For: Radiologists. 3-day Workshop, Apr. 23-25, Indianapolis. **CME Credit:** 21 hrs., AMA Cat. 1, AAFP. **Fee:** $125. **Sponsor, contact:** J. Roscoe, Prog. Coordinator, Postgrad. Med. Ed., Ind. U Sch/Md., 1100 W. Michigan, Indianapolis, IN 46202.

DIAGNOSTIC RADIOLOGY
For: MDs. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Science

GERIATOLOGY
For: MDs, paramedics, Nurses, etc. Wkly. Seminar, Apr. 8, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp./DuPage County, Avon & Schiller St., Elmhurst, IL 60126.

Surgery

BLOOD VESSEL SURGERY
For: Surgeons. 5-day Course, Apr. 14-18, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $300. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

FIBEROPTIC ESOPHAGOGASTRIC ENDOSCOPY
For: Specialists. 3-day Course, Apr. 28-30, Chgo. **CME Credit:** 19½ hrs, AMA Cat. 1. **Fee:** $250. **Sponsor, contact:** Ck. Cnty. Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

SURGICAL ANATOMICAL REVIEW
For: Surgical Residents. Month-Long Course, Ann Arbor. **CME Credit:** 105 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $300. **Sponsor, contact:** R. K. Richards, Dir., Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

SURGERY OF GASTROINTESTINAL TRACT
For: Surgeons. 5-day Course, Apr. 7-11, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

SEMINAR ON SURGERY AND MEDICINE FOR LAKE COUNTY
For: MDs, Dentists, Nurses, 1-day Seminar, Apr. 23, Waukegan, IL. **CME Credit:** 5 hrs., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** R. M. Adelman, DDS, MD, VP/Med. Affairs, St. Therese Hosp., 2615 W. Washington, Waukegan, IL 60085.

Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, Interns, 2-hr. Eve. Clinical Prog., Apr. 15, LaGrange Comm. Memorial Hosp., 5101 S. Willow Sprngs. Rd., La Grange, IL. **CME Credit:** 2 hrs., M Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons, 11255 W. 74th St., LaGrange, IL. 60525.

May, 1975

Arthritis

IMMUNOLOGIC CONSIDERATIONS IN MEDICAL PRACTICE
For: MDs, Second Wed. of Mo., June 11, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $30. **Sponsor contact:** U of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

ARTHRITIS IN INDUSTRY
For: Occupational MDs, Nurses, etc., 1½-day Scientific Sessions, May 23: 9:00-5:00; May 24: 9:00-12:00, Continental Plaza Hotel, Chgo. **CME Credit:** AAFP Elective, AMA Cat. 1 (# not yet allocated). **Sponsor, contact:** Central States Soc. of Industrial Med. & Surgery, 150 N. Wacker Dr., Chgo. 60606.

Cardiology

HYPERTENSION
For: All MDs. Symposium, May 13, 8:30 AM, Melrose Pk, IL. **CME Credit:** 1½ hrs., AMA Cat. 2. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp. 1225 Superior St., Melrose Park, IL 60160.

ELECTROCARDIOGRAPHY '75
For: MDs, RNs, 1½-day Symposium, May 8-9, Holiday Inn East, Springfield, IL. **CME Credit:** 10 hrs., AAFP Elective. **Fee:** $25. **Sponsor, contact:** Ill. Heart Assoc., 1181 N. Dirksen Parkway, P.O. Box 2666, Springfield, IL 62708. **Co-sponsor:** AHA Council on Clinical Cardiology.

Dermatology

For: Dermatologists. 5-Day Course, May 5-9, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Family Medicine

27TH ANNUAL POSTGRADUATE SEMINAR
For: Family MDs, Symposium, May 18-22, Arlington Park Hilton, Arlington Heights, IL. **CME Credit:** 16 hrs., AMA Cat. 1, AAFP prescribed. **Fee:** $10 (non-members). **Sponsor, contact:** H. Marchmont-Robinson, MD, Ex. Dir./Ill. Acad. of Family Physicians, 14 E. Jackson Blvd., Chgo. 60604.

General Medicine

STATE & NATIONAL BOARD REVIEW COURSE, CLINICAL
For: All MDs. 6-Day Course, May 14-19, Chgo. **CME Credit:** 52 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

DIABETIC KETOACIDOSIS
For: MDs & Nurses in IL, Symposium, May 7, 9:00, Chgo. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.

MYASTHENIA GRAVIS
For: MDs & Nurses in IL, Lecture, May 28, 11:00 AM, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, 2 hrs., AAFP. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

GENERAL MEDICINE LECTURE SERIES
For: House Staff & Gen. Staff, Lecture Series, May 6, 13, 20, 27, Chgo. **CME Credit:** 18 hrs., AAFP Elective. **Sponsor, contact:** A. Sapienza, MD, Dir/Med. Ed., St. Mary of Nazareth Hosp., Cntr., 1120 N. Leavitt St., Chgo. 60622.

Internal Medicine

ADVANCED CARDIOLOGY
For: Cardiologists. 5-Day Course, May 19-23, Chgo. **contact:** Cook County Grad. Sch./Med., 707 S. Wood **CME Credit:** 30 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor,** St., Chgo. 60612.

INTERMEDIATE ELECTROCARDIOGRAPHY
For: All MDs. 2-Day Course, May 8-9, Chgo. **CME Credit:** 14 hrs., AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING
For: Internists. 6-Day Course, May 12-17, Chgo. **CME Credit:** 60 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Medical/Legal Problems

MEDICAL/LEGAL PROBLEMS
For: MDs. Second Wed. of Mo. May 14, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

Musculo-Skeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, & Interns. Eve. Clinical Program, May 8, Michael Reese Hosp., 2929 S. Ellis, Chgo. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons. 11255 W. 74th St., LaGrange, IL 60525.

Pediatrics

ADVANCES IN PERINATAL MEDICINE
For: MDs & Nurses, Symposium, May 15-16, 8:00-5:00, Henrici's Clock Tower Inn, Rockford, IL. **CME Credit:** (Applied for). **Fee:** $35. **Sponsor, contact:** G. Staub, MD, Rockford Memorial, Rockford School of Medicine, IDPH, Rockford, IL.

COMMON GENETIC DISEASES
For: Pediatricians. 5-Day Course, May 19-23, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1.**Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

NO TITLE AVAILABLE—ANNUAL DINNER MEETING
For: Pediatricians. Regular Annual Dinner, May 21, Ambassador West Hotel. Dinner: $12, Social Hr.-6:00 PM. Dinner-7:00 PM. **Sponsor:** Chicago Pediatric Society. **Contact:** L. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

Radiology

REFRESHER COURSE IN RADIATION SCIENCE FOR THE RADIOLOGIST
For: Radiologists. 7-Day Course, May 19-25, Chgo. **CME Credit:** 59 hrs., AMA Cat. 1. **Fee:** $330. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Surgery

ADVANCES IN SURGERY
For: Surgeons. 5-Day Course, May 12-16, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

SURGERY
For: Ophthalmologists & Residents. Lecture & Symposium, May 23-24, Drake Hotel, Chgo. **CME Credit:** 12 hrs, AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** Chgo. Ophthalmological Society, 1206 Oakwood Dr., McHenry, IL 60050.

SURGERY
For: Opthalmologists & Residents, Lectures & Symposium, May 23-24, Drake Hotel, Chgo. **CME Credit:** 12 hrs., AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** T. Chalkley, MD, Chmn./Chgo. Ophthalmological Society, 1206 Oakwood Dr., McHenry, IL 60050.

CARDIOVASCULAR SURGERY
For: MDs. Discussion/Lecture/Discussion, May 9: American Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood. 6:00 PM; May 10: Bethesda Hosp., Chgo., 10:00 AM. **CME Credit:** 5 hrs, AMA Cat. 1. **Fee:** $10. **Sponsor, contact:** P. Pierdinock, American Hosp., 850 W. Irving Park Rd., Chgo. 60613.

PATHOLOGY OF DIABETES
For: MDs & Nurses, Lecture, May 7, Chgo. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Thyroid

CURRENT CONCEPTS REGARDING THYROID DISEASE
For: MDs, Paramedics, Nurses, etc., Wkly. Seminar, May 6, 11:30-12:30, Elmhurst, IL. **CME Credit:** 1 hr. AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir/Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

June, 1975

Drugs

DRUG INTERACTIONS
For: MDs, Paramedics, Nurses, etc., Wkly. Seminar, June 24, 11:30-12:30, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir/Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

Family Medicine

NORTHERN MICHIGAN SUMMER CONFERENCE
For: (Gen. Interest), 5-day Wkshp-Course, June 23-27, Shanty Creek Lodge, Bellaire, Mich. **CME Credit:** 24 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intraumural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

FAMILY PRACTICE REVIEW-PART I
For: All MDs, 3-Day Wkshp., June 10-12, Stouffer's Inn, Indianapolis, Ind. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** Postgrad. Med. Ed., Ind. U Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

General Medicine

ACIDOSIS AND ALKALOSIS
For: MDs, Discussion/Lecture/Discussion, June 20: Bethesda Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood, IL, 6:00 PM; June 21: Forkosh Memorial Hosp., Chgo. 10:00 AM. **CME Credit:** 5 hrs., AMA Cat. 1. **Fee:** $10. **Sponsor, contact:** Neil Glass, Bethesda Hosp., 2451 W. Howard St., Chgo. 60645.

Internal Medicine

ADVANCES IN INTERNAL MEDICINE
For: Internists, 4-Day Wkshp.-Course, June 3-6, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 28 hrs., AMA Cat. 1. AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

Obstretics & Gynecology

SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY
For: Ob-Gyn, 10½ day Course, June 2-13, Chgo. **CME Credit:** 86 hrs., AMA Cat. 1. **Fee:** $350. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pediatrics

NEUROMUSCULAR AND LEARNING DISORDERS IN CHILDREN
For: MDs, 5-Day Course, June 9-13, Chgo. **CME Credit:** 27 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pulmonary Disease

PULMONARY DISEASE WORKSHOP
For: Family MDs, 2-Day Wkshp.-Course, June 11-12, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

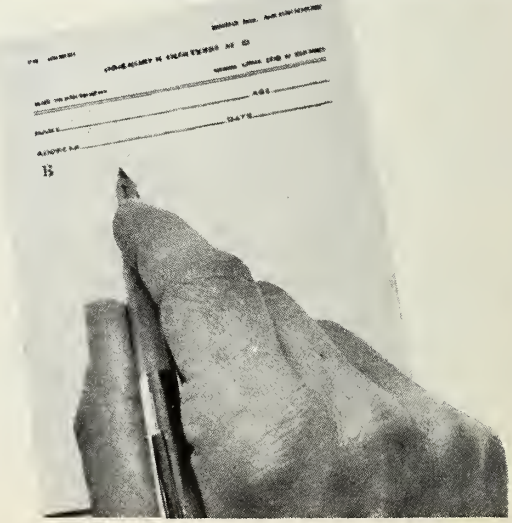
Surgery

MANAGEMENT OF TUMORS OF HEAD AND NECK
For: Surgeons, 5-Day Course, June 9-13, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Case-Discussion & Problem-Solving

In response to the growing use of case-discussion for in-hospital continuing education, ICCME has produced a brief manual on how to conduct effective case-discussion. It includes step-by-step instructions, as well as *four* tested cases that you can use as is, or as models for developing your own discussion cases.
Copies of this manual are *free* to Illinois physicians and CME sponsors, and $2.00/copy to all others. For *your* copy, write to ICCME, at the address above.

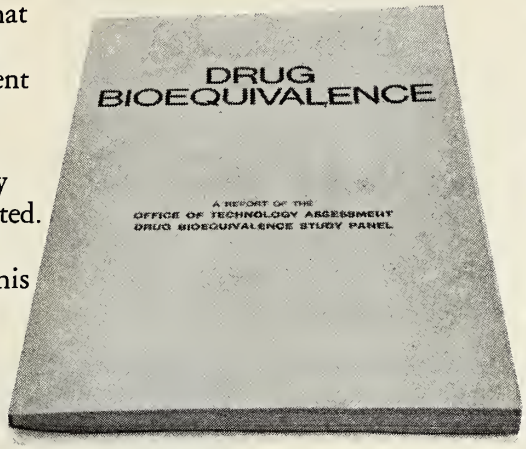
Bioequivalence



the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*



Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.

"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription

Hypernephroma in a Child

By Ruth Andrea Seeler, M.D., and Hugh Firor, M.D./Chicago

A 6 years, 8 months old Black female with a massive renal adenocarcinoma was treated preoperatively with a single dose of vincristine and 1,000r administered over five days. There was dramatic reduction in tumor size facilitating operative removal. It would appear that in selected cases preoperative vincristine and radiotherapy would be a valuable adjunct. Postoperatively, the child received an additional 2,000r and a single course of actinomycin D. She is currently tumor free 48 months following the operation.

Renal cell carcinoma, hypernephroma, is a rare malignancy in the pediatric age group. In the English literature there are approximately 64 accepted pediatric cases.[1,4,5,8,9,11] A recent review has concluded that this tumor is even rarer in Black children.[4]

Prognosis is thought to be related to the tumor size and to the extent of disease at the time of operation. [1,7] In adults, hypernephroma is considered to be radioresistant and not particularly responsive to chemotherapy.[2] We are reporting a Black female child with a large tumor which showed dramatic reducation in size with preoperative vincristine and radiotherapy.

Case Report

The patient, a 6 years, 8 months old Black female, was admitted with a large abdominal mass. The mother had been aware of the presence of a tumor for at least three months, but because it was asymptomatic she did nothing about it. Following a fall, the child complained of pain and was brought to the hospital.

Physical examination revealed a cooperative, symmetrical, normal tensive (100/60) child with normal height and weight percentiles. The left side of the abdomen was visibly distended by an irregularly lobulated firm mass which extended from under the ribs to beneath the symphysis pubis and across the midline (Fig. 1).

The intravenous pyelogram showed blunting of the calyces of the left collecting system. No calcifications were noted.

Pertinent laboratory data included a hemoglobin of 11.1 gm%, hematocrit 33%, WBC and differential were normal. The erythrocyte sedimentation rate was elevated at 42 and 53 mm/hr. Protein electrophoresis, blood urea nitrogen, calcium, and alkaline phosphatase were within normal limits. The urinalysis initially was negative for occult blood but became positive during hospitalization.

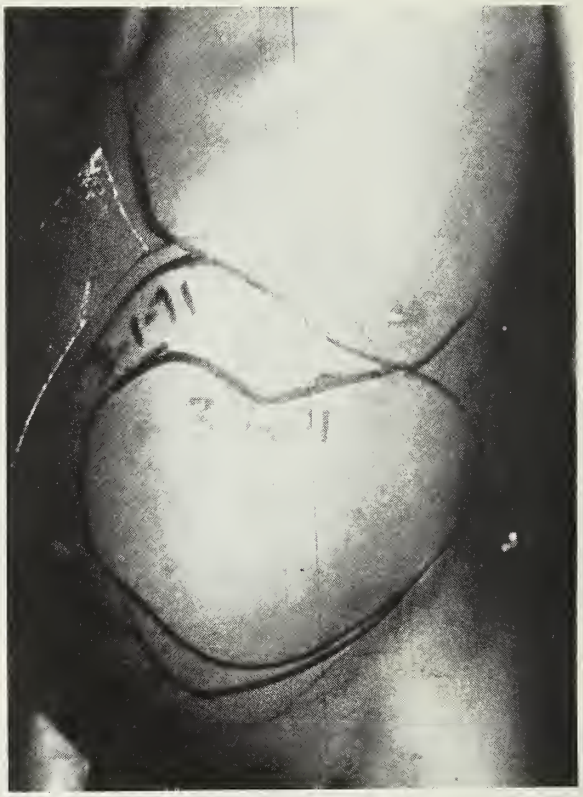


Figure 1. Tumor size before and after 1 dose of vincristine and 1000r.

Believing the tumor to be a technically inoperable Wilm's tumor, an attempt was made to reduce its size. The patient received a single dose of vincristine 0.05mg/kg and 1,000r tumor dose delivered over five days. The tumor response was dramatic (Fig. 1). A week after starting therapy, the upper edge of the tumor could be palpated beneath the ribs; the tumor no

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HUGH FIROR, M.D. is a Pediatric Surgeon, Cook County Hospital, Hektoen Institute for Medical Research.

longer crossed the midline and the nodularity was no longer visible. The patient was kept well-hydrated and no elevation of the uric acid occurred.

The patient had had daily temperature elevations in excess of 103-104°F. The temperature elevations were noted on admission and were documented for several days prior to chemotherapy and radiotherapy. The height of the temperature elevation decreased markedly with the tumor response. On the two days preceding operation, the temperature remained under 101°F (Fig. 2). No source of infection was found and no antibiotics were given.

On the tenth hospital day, a 1,075 gram tumor measuring 16x12x10cm was removed, *en block*, which on microscopic examination proved to be a mixed cell adenocarcinoma (Fig. 3). No gross or microscopic vascular invasion was noted. The lymph nodes adjacent to the tumor were free of disease.

Following the operation, the patient became afebrile and remained so. Postoperatively, she received an additional 2,000r tumor dose and a five day course of actinomycin D 0.015mg/kg/day x5. Wound healing was prompt; convalescence was smooth. The patient had no evidence of disease 28 months following operation.

Discussion

Because of the rarity of this tumor in the pediatric age group, prognostication is difficult, and it is most important to record both therapeutic successes and failures.

Therapy for renal carinoma has been throughly reviewed and summarized by Bennington and Kardjian.[2] Although generally considered radioresistant, many renal carcinomas are surprisingly radiosensitive. They concluded that, "if the tumor is extremely large, reducing its size by a preoperative radiation may make its surgical removal possible, or may allow the surgeon to remove it more expeditiously."[3]

As a general rule, preoperative irradiation without a histiological diagnosis is a dangerous procedure. However, all centers caring for a large number of children with malignancy occasionally have patients in whom this seems to be a justifiable approach. In our patient, the administration of 1,000r over five days in conjunction with a single dose of vincristine reduced the tumor size dramatically. This rendered the operative approach far safer and, thus, may have contributed to the favorable course to date.

The role of postoperative radiation therapy seems unsettled. There are several patients in whom postoperative irradiation seems to have contributed to the favorable outcome.[5-7,11]

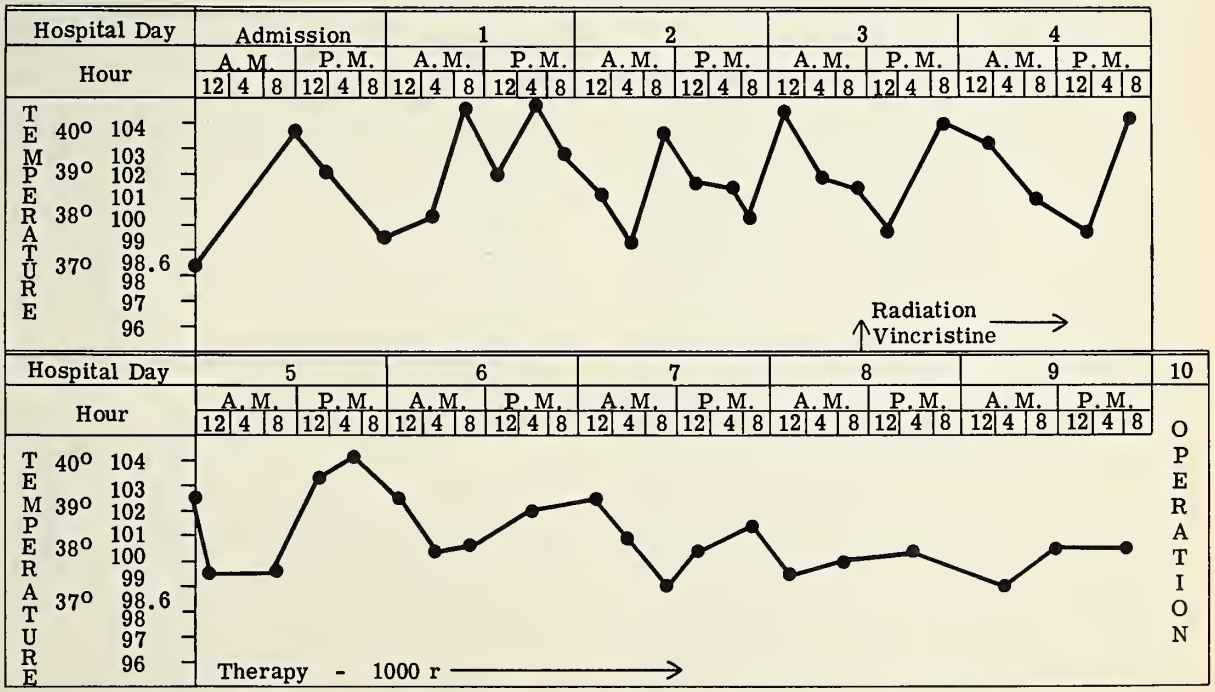


Figure 2. Temperature chart before and during vincristine and radiotherapy.

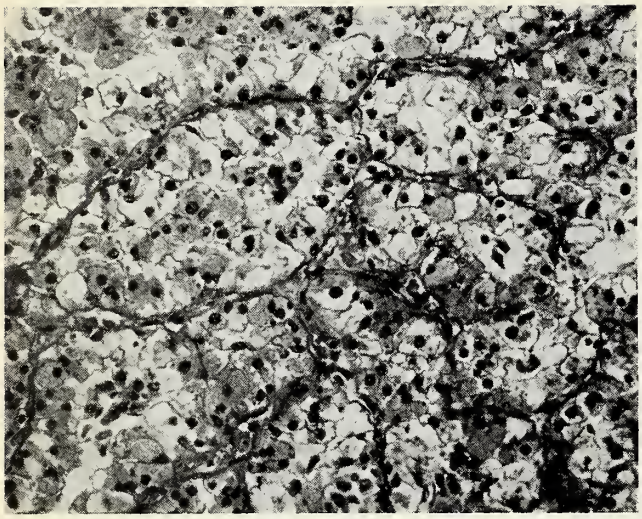


Figure 3. Representative section from the tumor with cells resembling tubular epithelium with round, small, nuclei with granular pink cytoplasm, mixed with numerous cells with complete vacuolation of the cytoplasm. (H and E).

Renal carcinoma is generally considered relatively resistant to chemotherapy.[2] However, one must acknowledge that the subject may need reevaluation. One recent report details the conversion of an unresectable renal carcinoma into an 8½ year no evidence of disease "cure" with multiple drug chemotherapy and radiotherapy.[5] In our patient, we selected vincristine initially because of its effectiveness in Wilm's tumor, which was our working diagnosis. We administered the actinomycin D concurrent with the surgery and postoperative radiation.

The prognosis seems directly related to the extent of the tumor at operation and the presence or absence of renal vein invasion.[1,4,7] When the tumor is totally resectable, one reviewer calculated a 75% survival rate.[1] The prognosis for our patient seemed fairly good at 48 months, with no evidence of disease. Most patients with renal carcinoma who develop metastases do so by two years.[1,4]

This patient demonstrated the hyperpyrexia frequently associated wtih renal carcinoma. During the initial workup, the patient exhibited daily temperature elevation in excess of 103-104°F. The temperature spikes antedated all therapy and became markedly less during chemothrapy and radiation therapy, and ceased postoperatively. The hyperpyrexia is believed to result from an endogenous pyrogen produced by the tumor tissue.[10]

In spite of the large size of this child's tumor, none of the other extra-renal manifestations frequently associated with renal carcinoma (elevation of the alpha-2 globulins, hypercalcemia, polycythemia, leukamoid reaction, or weight loss) were noted.[8]

It is somewhat disheartening to realize that the presence of a mass does not suggest malignant tumor and worry a parent. The parents of our child were conscientious in all other respects and she was well cared for. Although the mother admitted she "wondered what it was," she had not been concerned initially because there was no associated pain. ◄

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Plan to attend

President's Night

Dinner-Dance

Thursday, April 3, 1975

Sterilization and Therapeutic Abortion Counseling for the Mentally Retarded

By Charles W. Smiley, M.S.W./Kingston, Ontario

Providing counseling in the extremely sensitive areas of sterilization and therapeutic abortion is one of the most difficult tasks facing a professional worker. It is even more difficult when the patient is mentally retarded or when one is working with a family who has a retarded member. This article will attempt to provide some basic principles to meet this challenge.

The problems concerning sterilization, therapeutic abortion and mental retardation seem to focus in two main areas.

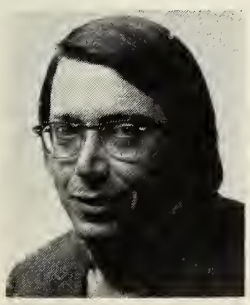
1. The improvement of the physical and emotional health of the retarded patient by eliminating or limiting the stresses of child bearing and rearing.
2. The *primary* prevention of potentially severe mental retardation in certain "high risk" pregnancies.

Concerning item number one, the first principle would seem to be:

> *Assessment of a patient as to her suitability for abortion or sterilization on the grounds of mental retardation must include psychological testing, assessment of the patient's social situation and psychiatric interview.*

Objective assessment of limited cognitive abilities requires the skills of a psychometrist or a psychologist. The diagnosis of mental retardation implies the patient has scored below 70 on a standardized intelligence test. The professional involved with the patient has to work closely with a psychiatrist or other physicians to provide an opinion on the emotional stability of the patient.

The main handicap in mental retardation is usually seen as a cognitive one. This would include defects in thinking, learning and calculation. However, an assessment of the retarded patient also must consider the affective or emotional factors. As a rule, the mental defect is accompanied by more or less mental instability. The degree of stability varies markedly in different retarded individuals and at different times in the same individual.



CHARLES W. SMILEY, M.S.W., is Assistant Professor, School of Social Welfare, Univ. of Calgory. A graduate of Oregon State and Portland State Universities, he is also currently Chief Social Worker at the Rockwood Mental Retardation Unit of Kingston Psychiatric Hospital, Kingston, Ontario.

This would seem to include the majority of the retarded. However, some retarded individuals are quiet, good natured, placid, and inoffensive. They are not insensible to pleasure and they exhibit delight. They are also conscious of and affected by praise, rebuke or ill treatment. Usually their joy or sorrow is neither excessive nor of long duration; and their general demeanor is that of happy placidity.

> *When the social assessment reveals the patient cannot function as an independent citizen or where the psychological testing reveals an I.Q. of 55 or less, the consent of the patient is inadequate and an appropriate substitute must be found.*

Laidlaw and Bass[1] in their discussion of sterilization have concluded that "the individual who is capable of living in the community is able to understand the meaning of the operation and is almost always willing to have it." This would include therapeutic abortions. It is suggested that in cases where the retardate lives independently in the community no further consent is needed or required. However, if the patient is married, the consent of the husband should be obtained. If the patient is to some degree dependent for support from her family, then their consent should be obtained. In all cases of an I.Q. under 55, the consent of the family must be obtained.

The publication "The Law and Mental Disorder"[2] deals with the special case where the patient is considered incompetent in this regard, is hospitalized, and no next-of-kin is available. It states, "the superintendent may authorize action by the physician in charge but it is advised that the superintendent first must have a

consultation with another medical person as to the need for treatment."

> *Sterilization and abortion should be recommended and should be easily available for retardates when their I.Q. is less than 55. This should also be true for retardates with an I.Q. range of 55 to 70, where significant "emotional instability" factors are present.*

For the purposes of discussion in this section, I propose to divide retardation into two categories, "slight" and "marked." The I.Q. of 55 will divide the two divisions.

I agree with the British recommendations[3] that marked retardation is definite grounds for abortion. Because of the inability of this group of patients to make use of contraceptives, I feel sterilization also should be both recommended and made easily available. The modern trend of management in mental retardation is to keep as many of the retarded as possible in the community. The sense of relief provided to the families of the retarded and to the community itself when the risk of reproduction is no longer present allows the patient a degree of freedom not hitherto available. In the traditional environment of the isolated institution where the sexes have been segregated, reproduction was not a major problem. This is not the case in the community. The behavioral abnormalities, such as aggressivity and extreme dependence, which seem to be a reaction to excessive surveillance and which themselves have added to the patient's handicaps, are prevented.

In the cases of "slight" retardation, the indications are somewhat less clear and the evaluation of the patient's emotional stability and social situation assume relatively more importance. The retarded are more prone to emotional instability[4]. Another factor is that retarded patients' ability to satisfactorily care for their children rapidly declines when their family extends beyond two children[5].

I would suggest sterilization or abortion be recommended and available in all cases where the retardate is rated as emotionally unstable. For the stable retarded, sterilization or abortion should be available and recommended at any time after two children are born. A previously stable retardate, who becomes unstable after the birth of her first child, should be recommended for sterilization.

Concerning primary prevention, the basic guideline would seem to be:

> *The deleterious effect on the health of the mother in caring for a severely retarded child is grounds for sterilization or abortion, where the risk of birth of such a child is demonstrably increased.*

There are a number of situations where sterilization or abortion are indicated because of an extremely high risk, compared with the general population, that a child would be retarded. New preventive techniques such as amniocentesis are being researched. These techniques promise to make intervention more reliable and selective.

There is a group of cases where the genetic risk is less clear, but still present. As an example one can use the mother over 35 who is concerned about having a child with Down's Syndrome. The British Medical—Psychological Association memo on therapeutic abortion[3] states, "where the parents already have children, the termination of a pregnancy in which the risk of abnormality in the child is substantially enhanced, would appear to be justifiable." In my view, this seems quite appropriate. With the current legislation in Canada, the risk may have to be considered from the point of view of the health of the mother. However, the deleterious effects that raising a severely handicapped child can have on the mother's physical and mental health are well documented[6]. This may justify both abortion and sterilization.

Consideration of the genetic aspect in mild mental retardation reveals the evidence is less clear and at times apparently contradictory. It seems advisable to consider mild retardation in the context of risks to the mental and physical health of the mildly retarded mother. ◄

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Atlantic City

(Continued from page 202)

6. Oppose a 1974 resolution—referred to the Board for study—which would have ISMS offer its assistance to the legal profession in establishing a peer review system for lawyers.
7. Amend the bylaws to permit the immediate past president to serve as chairman of the Board of Trustees in the latter's absence.
8. Amend the bylaws to provide the following dues payments schedule:
 A. January 1—dues payable to component society.
 B. February 1—component society to notify unpaid members that February 15 is final date for dues payment.
 C. March 1—deadline for component society to forward dues and membership roster to ISMS.
 D. March 15—ISMS to notify unpaid members of delinquency.
 E. April 1—unpaid members to be dropped.

 Thereafter a new member application would be required for reinstatement.
9. Establish a policy indicating that—unless physicians appointed to the boards of other organizations, such as local Comprehensive Health Planning "b" agencies, are nominated by their county medical society—such physicians shall not be considered "representative" of the medical community.

The Board also directed the Executive Committee to consider introducing a resolution that would allow remuneration for the President and the Chairman of the Board. The Committee on Constitution & Bylaws was instructed to review the standards of procedure of the Board and the AMA Delegation, spelling out in appropriate language the duties and responsibilities of each as they relate to AMA activities.

Committee and Council Appointments

The Board approved appointment of Dr. A. K. Busch, Belleville, to the Council on Mental Health and Addiction; Drs. B. Franklin Lounsbury, Chicago, and William Henry, Springfield, to the Insurance Committee; and Dr. P. John Seward, Rockford, to the National Legislation Committee.

Finance Committee Actions

The Board approved a 1975 budget of $1,247,442 with the following breakdown of individual dues as approved by the House:

AMA-ERF	$ 10.00
ICCME	10.00
BENEVOLENCE	5.00
IMJ SUBSCRIPTION	4.00
STUDENT, INTERN, RESIDENT ASSES.	1.00
OPERATING FUND & SPEC. ALLOCATION	101.00
TOTAL	$131.00

The budget is based on income from an anticipated 10,100 regular dues paying members. A Benevolence Fund budget of $50,400 was also adopted.

The Board also received for information the 1974 year-end financial report indicating an unaudited deficit of $9,504 as compared to an anticipated deficit of $15,273. A projected 1976 budget of $1,322,000 was accepted for presentation to the House of Delegates. According to Finance Committee Chairman Dr. Mather Pfeiffenberger, 1974 expenditures were only 1½% over budget, although the cost of living rose 11.2% during the year.

Finance Committee actions ratified by the Board included a cost-of-living disbursement to staff; allocation to Equipment Replacement Fund to accommodate move to new quarters; reimbursement of advances for IPSRO to the Educational & Scientific Foundation from special assessment fund; continuation of AMA-ISMS New Membership Incentive Rebate Program for county societies; sharing with county societies income received from AMA for early dues remittance; establishment of reserves for future elections to AMA Offices; participation by officers and trustees over age 71 in the Group Accident plan and by past officers and trustees at their own expense; and expenditure up to $2,500 for a bicentennial project.

Acting on information that some members have paid their 1975 dues but still refuse to pay the $25 assessment voted by the House of Delegates, the Board di-

rected that memberships for these physicians be listed as conditionally accepted but payment of dues incomplete in respect to full dues payment. Final determination of membership status will be made by the House at the 1975 annual meeting. Members so classified will be notified of this action in a letter over the president's name, with the letter pointing out the reasons for the action and with appropriate reports enclosed.

With regard to the AMA special assessment, the Board requested officers of the ISMS delegation to prepare a report to the membership outlining the reasons for it. In a related action, the Board approved a suggestion that a member of the AMA delegation accompany the president on his annual tour.

Physician Shortages

ISMS will help the nine physician-short Illinois counties eligible for assignment of National Health Service Corps physicians by: (1) Obtaining a NHSC application for the community and assisting in completion and filing of application; (2) Soliciting help of congressmen in urging HEW assignment of physicians to their areas; and (3) Assisting physicians so assigned to establish practice.

To help all physician-short Illinois communities, ISMS will sponsor a Doctors' Job Fair February 23 at the Continental Plaza Hotel, Chicago. More than 50 communities are expected to participate, paying $70 each for exhibit space to interview physicians who are looking for practice locations.

The Board also authorized the Committee on Health Care of the Poor and Rural Problems to develop a program for medical students, which would give them an insight into the advantages of practicing in physician shortage areas. This program would be conducted in cooperation with the medical schools.

In view of the physician shortage in Illinois, ISMS will request the Department of Registration and Education to delete from its physician application for temporary license an affidavit certifying that the out-of-state applicants will not practice in Illinois upon completion of a residency here.

Utilization Review Meeting

The Board approved use of special assessment funds to pay travel expenses of participants in the January 9 meeting which ISMS sponsored to consider methods of meeting utilization review requirements outside of areas where PSROs are being established. At the meeting, the Illinois Foundation for Medical Care revealed plans for establishment of a unified system of UR committee performance throughout Illinois, administered by local physician medical care monitoring groups, to enable hospital UR Committees to comply with the regulations. IFMC will be asked to adopt a suitable name for this proposed institutional program.

Peer Review

The ISMS Peer Review Appeals Committee will develop guidelines for an educational program that could be offered to county and district peer review committees. The program would demonstrate a standard peer review procedure and encourage local committees to carry out their important responsibilities.

The Council on Economics and Peer Review has prepared a form for use by physicians to obtain fee profile data from Medicare carriers. It has been approved by the Board of Trustees and is available to all members upon request. The Board also authorized an inquiry into the accuracy of charge screens for Medicare reimbursement which was requested by the Council on Mental Health and Addiction.

In a related action, the Board agreed to invite the Illinois Psychiatric Society Peer Review Committee to work collaboratively with the ISMS peer review process in an advisory role. Local peer review committees would be encouraged to refer appropriate psychiatric questions to the joint IPS-ISMS committee which should advise the local committee of its determination. The local or district committee is responsible for making a final determination and informing all interested parties of its decision. A similar process would be followed in matters being appealed to the ISMS Peer Review Appeals Committee.

Use of Current Procedural Terminology and Uniform Claim Form

The Board again encouraged physicians to use AMA's standard insurance form

when submitting claims to all third payors and to use AMA's Current Procedural Terminology, 3rd Edition, for coding all procedures. MDs also should charge insurance carriers who insist upon a form other than the standard claim form. Carriers will be notified of this policy and members will be sent information on obtaining the forms.

Position on School Physicals

The Board adopted a position statement on school physicals covering their purpose, scope, examiners and responsible agents. Because of the difficulty in fulfilling legal requirements for school physicals, ISMS will seek legislation that will permit examinations be done six months prior to or after the child's admission into school and will recommend that the Department of Public Health develop a uniform recording form to facilitate reporting throughout Illinois.

Annual Meeting

The Board endorsed three programs to be conducted in conjunction with the Midwest Clinical Conference and annual meeting of ISMS, April 2-5 at the McCormick Inn, Chicago. They include a regional AMPAC meeting, an all-day session on the medical management of alcoholism, and an educational program for medical directors of long-term skilled nursing facilities at which time new federal regulations will be explained.

The Board also agreed that the annual ISMS Journalism Awards be presented during one of the sessions of the House of Delegates in April.

Emergency Medical Services

The Board approved guidelines for an ISMS Emergency Medical Services Award and authorized the Committee on Emergency and Disaster Care to consider nominees for the award. The chairman of this committee will serve as the society's representative on a new advisory council composed of representatives of the Illinois Hospital Association, Emergency Medical Services Commission of Chicago, American College of Emergency Physicians, Illinois Nurses Association, Emergency Department Nurses Association, Chicago Hospital Council, Committee on Trauma of the American College of Surgeons, and the Chicago Committee on Trauma.

The Committee on Emergency and Disaster Care was also authorized to work with community service organizations in exploring the feasibility of a bicycle and motorcycle safety program throughout the state.

Public Relations Key-Man Program

The Public Relations Council will establish a key-man program, in cooperation with the appropriate county medical societies, in the metropolitan areas of Rockford, Rock Island, Joliet, Peoria, Bloomington, Champaign, Danville, Springfield, Decatur and Belleville. Purpose of the program is to utilize relationships that exist between individual ISMS members and news media personnel for publicizing the position of medicine on various issues.

The council was also authorized to sponsor an informal buffet-reception for the Capitol press corps during the early stages of the General Assembly session.

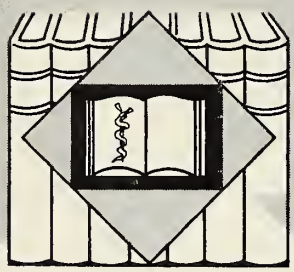
Registration and Education

ISMS will request the Department of Registration and Education for a report on its implementation of the Attorney General's recent ruling that chiropractors must take the same examination as physicians. ISMS also will inquire as to whether or not those chiropractors who have not taken the correct test might be practicing illegally.

Aspira Grant Request

A recommendation of the Council on Education and Manpower that ISMS grant another $10,000 to ASPIRA of Illinois was referred to the Executive Committee. The committee is authorized to make the grant if it is deemed appropriate. ◄

the doctor's library



VASCULAR SURGERY, Volume I: Peripheral Arterial Disease. John J. Cranley, M.D. Harper and Row, 1972. 282 Pages, Price, $19.95.

During the last decade, surgical treatment for peripheral vascular disease has evolved into a specialty within the sphere of surgery. This volume, written by a vascular surgeon and his colleagues, is a welcome addition to the field.

Eleven chapters, covering various aspects of the surgical practice dealing with peripheral vascular problems, are included. One notable omission is a discussion of chronic mesenteric artery ischemia.

Surgical technique for each arterial reconstructive procedure is illustrated by excellent drawings. Although there is no mention of the technique used, nor of the indications for, arteriographic examination, pathologic findings are exemplified by superior reproductions of the arteriograms.

All chapters are well balanced and harmonious in their presentation. The only drawback is the lack of emphasis on the physiologic alterations of blood flow and pressure associated with arterial stenosis or occlusion of vessels supplying different vascular beds. A concise introduction on the importance of the hemodynamic aspects of vascular disease would be helpful to students and house staff in understanding the disease process. The description of laboratory evaluation in circulatroy insufficiency also seems rather scant.

A unique feature of the volume is that each chapter is furnished with adequate references oriented toward surgical treatment. The book is recommended for trainees who are exposed to surgical treatment of peripheral vascular disease.

James S. T. Yao, M.D., Ph.D.

DERMAL PATHOLOGY. Edited by James H. Graham, M.D., Waine C. Johnson, M.D. and Elson B. Helwig, M.D. Harper and Row Publishers, New York. 1972, 818 pages. Price $45.00.

This is a profusely and beautifully illustrated compendium on dermal pathology with 17 noted contributors. Like many volumes consisting of contributions from multiple authors, this volume suffers from spottiness in coverage of the subject. It is not clear whether or not the editors intended to restrict the chapters to dermal as opposed to epidermal diseases. Drawing such a controversial line may explain the omission of psoriasis but not lupus erythematosus. The omission of lichen planus and the inclusion of lichen nitidus will puzzle many readers. Ichthyosis and acne are omitted. Acne rosacea is only mentioned in the differential diagnosis of lupus miliaris dissominatus faciei. Perforating folliculitis is only mentioned in the discussion of other perforating diseases. The chapter on stasis dermatitis is really an excellent discussion of lesions of the lower extremities and brings together such strange bedfellows as atrophie blanche, progressive pigmentary dermatoses, diabetic dermopathy, Kaposi's Sarcoma, lichen simplex chronicus and nummular dermatitis. Atopic dermatitis may well have been omitted for lack of specific histology.

The reader would do well to browse through the book and the index initially in order to become acquainted with the unusual grouping of diseases in certain chapters and the appearance of disease discussion in two different places as in erythropoietic protoporphyria. Overall this is an excellent book on the subjects which are discussed, but the reader cannot use it as an all inclusive reference book as is pointed out by the editors.

S. M. Bluefarb, M.D.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 360 North Michigan Ave., Chicago, 60601.

CARBONDALE: Family Practitioner wanted. Publicly funded out-patient clinic. 40 hour work week, plus liberal fringe benefits, salary open. Possible additional association: SIU Medical School; Emergency Medical Group; and/or thirty physician group practice. Contact: Geary Simmons, Director, Hays Center, 441 E. Willow St., Carbondale 62901 (618-549-0711). (5)

CHICAGO: General practioners needed for medical center. Complete office facilities. Generous salary. Part-time. Contact: Mrs. E. Tyler or Mrs. S. Hicks, 100 E. Garfield, Chicago 60653 (312-285-3008) (4)

CHICAGO: Cermak Medical Center wants a full-time or part-time physician with a good background in Internal Medicine; Cardiology, infectious diseases. A well rounded G.P. Contact: Mr. T. Ebie, Cermak Medical Center, 10 E. Cermak Rd., Chicago 60616 (312-225-2750) (4)

CHICAGO: Openings for Emergency Medical Physicians in emergency medical group serving two fine Chicago hospitals. Competitive financial compensation. Contact: Dr. M. Segal, 650 W. Wrightwood Ave., Chicago 60614 (312-327-0777) (4)

CHICAGO: Part-time doctors wanted for Chicago near south side clinic. Hours 9:30 a.m. to 1:00 p.m. or 12:30 p.m. to 4:00 p.m. Must have Illinois License and insurance. Must keep designated hours. Salary open and commensurate. Send medical background. Physician Recruitment Program, ISMS, 360 N. Michigan Ave., Chicago 60601. (5)

CHICAGO: Southeast side—Neighborhood Clinic. General Practitioner for Family Practice needed. Dentist and Optometrist present. Also X-Ray, EKG and Lab area on hand. Excellent Office facilities. Clinic now in 6th month of operation. Patient load—established and growing. Contact: Mr. G. Whitehurst or Mrs. Curry, 2505 E. 75th St., Chicago 60649 312-221-9270 (4)

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CLINTON: Population 8,200. Needs physician, four physicians at present. Centrally located, 25 miles from larger cities. Office facility available at present. Hospital with 44 beds, all services. Recreational facilities. Civic organizations. Good schools and churches. Contact: Robert Myers, M.D., 219 E. Main, Clinton 61727, 217-935-5022. (5)

DECATUR: Emergency Physicians—work two out of five weeks. Under 55, good health, excellent command of English required. Back ground in GP and/or Surgery desirable. Some teaching involved. Established incorporate group on fee for service. Contact with 400 bed hospital—Emergency Department with excellent profit and pension benefits. CONTACT: DECA Ltd., 2300 N. Edward, Decatur 62526 (217-877-8121) (6)

DANVILLE: Population 42,600. Interest in friendly small community with cultural and metropolitan advantages of larger cities? Interested in practicing in the new ED with plenty of interesting and challenging work? Interested in excellent salary plus fringe benefits? Full-time position available. CONTACT: A. J. Evans, Administrator, Lake View Memorial Hospital, Danville 61832 (217-443-5345) (6)

EAST ALTON: Immediate opening for industrial physician to direct extensive medical program at East Alton plant (St. Louis area). Medical facility is one of the most modern and best equipped in industry. Compensation, benefits and area highly attractive. Contact: MacRoy Gasque, M.D., Health Affairs, Olin Corporation, 120 Long Ridge Rd., Stamford CT 06904. (5)

GENEVA: GP's. OB-GYN, Ped, Internists, outstanding area with excellent practice opportunity. Ideal location for family living in the heartland of the Midwest. Geneva offers the charm of "New England" background—and all only 35 miles from the cultural and medical advantages of Chicago. Contact: L. C. Davis, Administrator, c/o Community Hospital, Geneva 60134 312-232-0771 (5)

ILLINOIS—Variety of settings in agencies providing diagnostic, treatment consultative and advisory services or administrative direction to medical programs. Completion of approved Medical School and 1 year internship-residency in approved hospital required. Must possess or acquire appropriate valid Illinois license before employment. Temporary certification not acceptable. Salary commensurate with skills and experience—good benefits. Equal Opportunity Employer—Male or Female. Send resume to: R. P. Gosnell, Manager, Illinois Department of Personnel, 521 State Office Building. Springfield 62706 (4)

JOLIET: 1 hour from Chicago. Very rewarding practice available. Owner retiring. Sacrificed for less than half. Best for any speciality, solo or group. Tremendous opportunity. Contact: Dr. P. Bagossy, 500 Western Ave., Joliet 60435 (815-722-1161) (7)

McHENRY: Immediate opening for Internists, Pediatrician, General Surgeon and Thoracic Surgeon. Outstanding opportunity to join multi-specialty group in mid-west resort area near Chicago. Salary with incentive from day one; fringe benefits and unusually good income potential. Group building directly connected to 143 bed community hospital. Contact: E. F. Wilt, Jr., M.D., McHenry Medical Group, 1110 N. Green St., McHenry 60050 (815-385-1050) (4)

McHENRY: Immediate openings for two full time physicians to augment present Emergency Service Department. Should be experienced in acute care but also sensitive to the needs of all primary care patients. Illinois license required. Hospital is a designated Trauma Center located 50 miles northwest of Chicago. The community offers modern schools, shopping facilities, and recreational areas. Flexible work schedules, competitive salaries, and malpractice insurance coverage. Send resume to: A. Corcoran, McHenry Hospital, 3516 W. Waukegan Rd., McHenry 60050 (7)

PINCKNEYVILLE: Population 3500—serves an area of 20,000. Medical group partnership of four physicians seeking fifth member. Complete office facilities—2 blocks from fully accredited hospital. Salary one year —then partnership. Good recreational facilities near St. Louis. Contact: C. E. Cawvey, M.D., 206 North Main St., Pinckneyville 62274 (618-357-2131) (4)

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Manuscripts should be typed, double spaced, and submitted in duplicate, one original and one carbon. An article should not exceed **12 to 16 manuscript pages,** (including illustrations) and should be briefer if possible. Please enclose personal glossy photos of author or authors. Snapshots are not suitable for reproduction.

References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

T. R. Van Dellen, M.D., Editor
Illinois Medical Journal
55 E. Monroe St., Suite 3510
Chicago, Ill. 60603

ATTENTION PHYSICIANS

The Illinois Department of Mental Health and Developmental Disabilities invites physicians to apply for challenging positions in its many facilities. A comprehensive program of mental health and retardation involving community and inpatient programs is established throughout the State.

Openings are available for physicians who qualify for an Illinois License with approved training in Psychiatry, Internal Medicine or General Medicine.

Salaries for Illinois Licensed Physicians range from $27,360 to $45,864 depending upon professional qualifications, experience and capability of assuming increasing professional responsibilities, i.e., Board Certified or Eligible Physician, commencing salary is $31,932.

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Interested doctors should write to the Medical Staff Employment Office, Illinois Department of Mental Health and Developmental Disabilities at 160 North LaSalle, Chicago, Illinois 60601, or call collect (312) 793-2719 between 9 AM to 4:30 PM.

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BLUE SHIELD REPORT FOR *Illinois Physicians*

Blue Shield's Usual and Customary Fee Program

When the Illinois State Medical Society's House of Delegates adopted definitions of "Usual, Customary, and Reasonable" fees in 1966, Blue Shield responded by developing ways of applying the definitions to future Blue Shield certificates. In May 1967 Blue Shield obtained approval from the ISMS House to apply the Society's definition to new Blue Shield accounts and to make payments to physicians on that basis.

Since August 1, 1967, when our first Blue Shield members chose protection under this method of payment, enrollment has increased and currently 65% of all groups have this type of payment coverage.

More than a year after Illinois Blue Shield offered Usual and Customary programs, The National Association of Blue Shield Plans amended its membership standards to require each Plan to make available a program to pay physicians' Usual, Customary, and Reasonable charges.

Blue Shield payments to physicians on this basis take into consideration charge patterns for similar services provided under similar circumstances in the same geographic area. Ongoing review and analysis of charge patterns provide the basis for revision.

Blue Shield's Usual and Customary program will not replace the indemnity programs which have characterized our Plan since its organization over twenty-five years ago, and which, despite shortcomings, have earned the endorsement and support of Illinois physicians.

Usual and Customary programs can have variations in the extent of payment. The major programs call for payment of 100% of Usual and Customary fees, but some are written at 80% with the patient being responsible for 20%. The popular Blue Shield 65, supplement to Medicare, is written at 20%. Other coinsurance figures are feasible and even first-dollar deductibles are not incompatible with these programs, although no such contracts are currently offered. However, in all these programs, the basis of payment is constant—the usual fees of the individual physician and the customary fees of similar medical practice within the area.

Special additions to the standard scope of benefits are evident in some certificates. For example, the Federal Employees Program covers consultation services, the HIA (farm groups) program covers the services of a surgical assistant.

By definition the Usual and Customary program will pay for usual and customary care and will make allowances for extra charges in unusual clinical circumstances when such circumstances are reported on our Physician's Service Report form. Payments are determined according to usual charges of physicians, both specialists and non-specialists.

An important purpose of the program is to reduce the number of partial payments based on fixed schedules of allowances and to eliminate patient insecurity arising from lack of predictability of medical care costs. By strengthening public confidence in the ability of the private sector to respond to changing conditions, we help to reduce the possibility of non-voluntary groups from influencing the practice of medicine and its financing.

Many professionals have asked the question: "Won't Usual and Customary coverage lead to fee schedules?" Only if the program is abused. For example, if Blue Shield failed to keep its data current then professional support in the program would be lost. Likewise, if physicians elevate their fees to seek maximum permissible payments, it would destroy the purpose of the program. Although there has been some evidence that charges were increased after our Usual and Customary program went into effect, our experience has shown that physicians have supported the concept and will preserve the integrity of the process.

The Illinois State Medical Society defines "Usual" as "that fee usually charged for a given service by an individual physician to his private patient—his own usual fee."

A fee is "Customary when it is within the range of 'Usual' fees charged by physicians of similar training and experience for the same service within the same specific and limited geographic area."

When the definitions of Usual and Customary are met, the term "Reasonable" may be applied.

Properly carried out with the understanding and continued cooperation of the medical profession, the Usual and Customary program will accomplish greater return for physicians from Blue Shield; a more appropriate share to physicians of the prepayment dollar; greater return to the public in benefits; and predictability of medical charges to the consumer.

Workshops set for May & June

The Spring schedule of workshops for medical assistants, announced in March issue of the "Blue Shield Report" is complete. Meetings for May and June are:

Thurs., May 1	Sheraton Inn	Springfield
Wed., May 7	Henrici's	Rockford
Thurs., May 8	Henrici's	Rockford
Wed., May 14	Ramada Inn	Bloomington
Thurs., May 15	Ramada Inn	Peoria
Thurs., May 22	Ramada Inn	Ottawa
Wed., May 28	Sheraton Inn	Rock Island
Thurs., May 29	Sheraton Inn	Galesburg
Thurs., June 5	Holiday Inn	Kankakee

Completing Essential Information on Medicare Claims

Accurate information on physician identification and completion of the physician's signature requirement are two essential items on the SSA 1490 Request for Medicare Payment form. When identification is incomplete or inaccurate, or the physician's signature is omitted, claims are delayed for a significant length of time before they can re-enter the processing and payment cycle.

Illinois Blue Shield, Part B Medicare carrier for Cook County, receives about 6,000 claims each working day or approximately 120,000 each month. Nearly 15 percent of the total received are delayed through errors or omissions in the SSA 1490 form, or because itemized statements containing the necessary information are not submitted with the claim form. The delays are expensive and time-consuming for both the physician and the carrier.

(1) Delays in obtaining accurate information on identification of the physician furnishing the service can be avoided by affixing a physician's imprinted label to the SSA 1490 form. The label contains the essential information on name, address and identification code number. Use of the imprinted label improves the carrier's processing time for making faster payments.

The label on the SSA 1490 form *does not mean* the physician is accepting assignment. This requires the signature of both physician and patient, and completion of the statement in the form that assignment is accepted.

A special mailing address and Box Number has been estabilshed to process orders for the imprinted labels. Requests should be addressed to:

Medicare Part B
Blue Cross/Blue Shield
Post Office Box 2218
Chicago, Illinois 60690
Attn: Update Unit

When you submit an SSA 1490 form without an imprinted label, *please complete item 8*, including your first name, last name, middle initial, address, zip code, telephone number and physician identification code number.

Newly licensed physicians without an identification code number *should complete* the SSA 1490 form *and item 8*, with their name, address, state license number, Social Security number and specialty if any. A physician identification code number will be assigned by Blue Shield, and the new physician notified by the carrier.

(2) Completion of the physician's signature item *is important.* It serves as documentation to the Part B Medicare carrier that the physician's services were medically necessary and personally rendered by him, or under his personal direction. Although the physician's actual signature is preferred, a stamp facsimile is acceptable for completing item 14, by the physician or authorized person in his office or medical facility.

(3) Another necessary item of identification that is often incomplete or inaccurate is the patient's Health Insurance Claim Number. If possible, please take the number directly from the patient's Health Insurance Card, including the letter suffix. New suffixes have been added recently for disabled Medicare beneficiaries. If the card is not readily available, please obtain the information before submitting the claim.

(4) Other major items that must be completed are: Diagnosis; itemization of all charges; and itemization of specific charges.

(a) The diagnosis is necessary for the Part B carrier to relate the services provided to the treatment of the illness or injury. It would be helpful if it was included on the physician's statement to the patient when billing the patient directly. This eliminates the need for contacting the physician for the diagnosis when the patient files for benefits and neglects to complete item 4 on the SSA 1490 form.

(b) Itemization of all charges involves listing the date of each service, place of service, description of each service, whether surgical or medical, the nature of the illness or injury, and charge for each service on the SSA 1490 form or statement to the patient. A bill, for example, that includes several office visits, plus in-hospital medical care, should list the date and charge for each office visit separately from the dates and charge for the in-hospital medical care.

(c) Itemization of specific charges requires listing the charges of each specific service included in an overall charge. An example would be a charge for an office visit during which a complete blood count and X-ray were taken. The specific fee should be shown for the complete blood count and X-ray, plus the charge for the office visit. For in-hospital visits, the charge should show the number of days the patient was visited and the charge for each day. If the charge for the initial visit exceeds that of subsequent visits, the difference in the amount charged must be shown.

Please review all claims for completeness before submitting them to the carrier.

Coverage of Vitrectomy Procedures

Part B Medicare payment may be made for two types of vitrectomy procedures: (1) simple vitrectomy, involving removal of vitreous humor and replacement with saline if there is a loss of vitreous, and (2) the more complex type used in cases of opaque vitreous and secondary retinal detachments. The latter procedures is the only one at this time which offers certain patients with vitreous-retinal abnormalities an opportunity for restoration of vision. The first is an accepted routine procedure performed in cataract surgery which prevents postoperative complications. The conditions for which vitrectomy is indicated are vitreous loss incident to cataract surgery, vitreous opacities due to vitreous hemorrhage or other causes, retinal detachments secondary to vitreous strands, proliferative retinopathy and vitreous retraction.

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when depression is primary

NORPRAMIN®
(desipramine hydrochloride)

HELPS PROVIDE EARLY CONTROL OF DEPRESSIVE SYMPTOMS...

Anxiety is an invidious symptom. It feeds upon sickness, gnaws, grows and invades every cranny of psychic pathology adding intensity to torment. Anxiety as a symptom secondary to depression may be so dominant that it obscures the primary diagnosis. It may suggest treatment with tranquilizers which often help. But as the vampire of legend had to have a laurel stake driven through its heart to truly die, so anxiety secondary to depression will not cease to nibble and bite until an antidepressant eradicates the primary illness—and symptomatic anxiety starves

Norpramin® (desipramine hydrochloride) 25 mg. and 50 mg. tablets.

IN BRIEF:

Indications: Norpramin® (desipramine hydrochloride) is indicated for the relief of depressive symptoms. Endogenous depressions are more likely to be alleviated than others.

Contraindications: Desipramine hydrochloride should not be given within two weeks of treatment with a monoamine oxidase inhibitor. Contraindications include the acute recovery period following myocardial infarction and hypersensitivity to the drug. Cross sensitivity with other dibenzazepines is a possibility.

Warnings: 1. Extreme caution should be used in patients: (a) with cardiovascular disease, (b) with a history of urinary retention or glaucoma, (c) with thyroid disease or those on thyroid medication, (d) with a history of seizure disorder. 2. This drug is capable of blocking the antihypertensive effect of guanethidine and similarly acting compounds. 3. *Use in Pregnancy:* Safe use during pregnancy and lactation has not been established. 4. *Use in Children:* Norpramin® (desipramine hydrochloride) is not recommended for use in children. 5. This drug may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. Therefore, the patient should be cautioned accordingly.

Precautions: This drug should be dispensed in the least possible quantities to depressed outpatients, since suicide has been accomplished with drugs of this class. If possible, dispense in child-resistant containers. It should be kept out of reach of children. Reduce dosage, or alter treatment, if serious adverse effects occur. Norpramin® (desipramine hydrochloride) therapy in patients with manic-depressive illness may induce a hypomanic state after the depressive phase terminates and may cause exacerbation of phychosis in schizophrenic patients. Use cautiously with anticholinergic or sympathomimetic drugs. Response to alcohofic beverages may be exaggerated. In the concurrent administration of ECT and antidepressant drugs one should consider the possibility of increased risk relative to benefits. Discontinue as soon as possible prior to elective surgery because of possible cardiovascular effects. Hypertensive episodes have been observed during surgery in patients on desipramine hydrochloride. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is neutropenia.

Adverse Reactions: *Cardiovascular:* hypotension, hypertension, tachycardia, palpitation, arrhythmias, heart block, myocardial infarction, stroke. *Psychiatric:* confusional states (especially in the elderly), hallucinations, disorientation, delusions; anxiety, agitation; insomnia and nightmares; hypomania; exacerbation of phychosis. *Neurological:* paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns; tinnitus. *Anticholinergic:* dry mouth, and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, hypotonic bladder. *Allergic:* skin rash, petechiae, urticaria, itching, photosensitization, edema (of face and tongue or general), drug fever. *Hematologic:* agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* anorexia, nausea and vomiting, epigastric distress, peculiar taste, abdominal cramps, diarrhea, stomatitis, black tongue. *Endocrine:* gynecomastia; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence, testicular swelling; elevation or depression of blood sugar levels. *Other:* jaundice (simulating obstructive), altered liver function; weight gain or loss; perspiration, flushing; urinary freguency, nocturia; parotid swelling; drowsiness, dizziness, weakness and fatigue, headache; alopecia. *Withdrawal Symptoms:* Though not indicative of addiction, abrupt cessation after prolonged therapy may produce nausea, headache and malaise.

Dosage and Administration: *The usual adult dose:* 50 mg. three times daily; increase if necessary after 7 to 10 days to maximum of 200 mg. daily. Dosages above 200 mg. per day are not recommended. *Maintenance:* At a lower dose adequate to maintain remission. *Adolescent and geriatric patient dose:* 25 to 50 mg. daily if necessary.

Overdosage: There is no specific antidote for desipramine, nor are there specific phenomena of diagnostic value characterizing poisoning by the drug. The principles of management of coma and shock by means of the mechanical respirator, cardiac pacemaker, monitoring of central venous pressure and regulation of fluid- and acid-base balance are well known in most medical centers. If heart failure is imminent, digitalize promptly.

LAKESIDE LABORATORIES
Division of Richardson-Merrell Inc.
Milwaukee, Wisconsin 53201

Obituaries

*Barrett, Russell, Missouri, died Feb. 14, at the age of 71. Dr. Barrett graduated from the University of Illinois in 1928.

Chickering, George, Nebraska, died Oct. 27 at the age of 88. He graduated from the University of Illinois in 1912.

*Curran, Walter, died Jan. 16 at the age of 62. Dr. Curran graduated from the St. Louis University in 1943.

**Davis, Ethel, Chicago, died Feb. 15, at the age of 80. She graduated from Rush Medical College in 1919. Dr. Davis has practiced medicine for over 50 years.

*Depoian, Haig, Chicago, died Feb. 8, at the age of 67. He graduated from Midwest Medical College in 1934.

*Fox, Ronald, Hoffman Estates, died Jan. 28, Dr. Fox graduated from the University of Illinois in 1953.

**Furno, Peter, California, died Jan. 29, at the age of 81. He graduated from the Chicago College of Medicine in 1915. Dr. Furno was past president of the Chicago Medical Society-Northwest Branch and past president of the Illinois State Medical Society. Dr. Furno has practiced medicine for over 50 years.

Jones, Marshall, died Oct. 12 at the age of 75. Dr. Jones graduated from Northwestern in 1927.

*McClay, Elmo, died Feb. 2, at the age of 68. Dr. McClay graduated from Nebraska University in 1938.

**Motis, Marie, Oak Park, died Jan. 29, at the age of 90. She graduated from the University of Illinois in 1913. Dr. Motis was a general practitioner, registered pharmacist, teacher of ophthalmology and opened four nurseries in the area.

*Narat, Joseph, California, died Jan. 27, at the age of 87. Dr. Narat graduated from the University of Heidelberg in 1911.

**Oliver, Henry, Arizona, died Dec. 8, at the age of 81. He graduated from the University of Illinois in 1920. Dr. Oliver practiced medicine for over 50 years.

*Orlow, Walter, died Feb. 4, at the age of 47. Dr. Orlow graduated from Ohio State University in 1955.

Quistgard, Paul, Missouri, died Oct. 28 at the age of 69. He graduated from Northwestern University in 1930.

*Rand, Morris, Chicago, died Jan. 29, at the age of 65. He graduated from Chicago Medical in 1942. Dr. Rand was on the staff of South Chicago Community Hospital for more than 30 years.

**Rundquist, Matthew, Rockford, died Jan. 13 at the age of 96. He graduated from Chicago Medical School in 1905. Dr. Rundquist is the oldest member of the Winnebago County Medical Society.

*Shepard, Henry, died Dec. 30, at the age of 74. He graduated from the University of Louisville in 1931. Dr. Shepard was a surgeon specializing in ear, nose and throat.

Indicates ISMS member
Indicates ISMS member and member of the Fifty Year Club

PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N0047-0250-51) and 1000 (N0047-0250-60); ½ grain tablets in bottles of 100 (N0047-0251-51) and 1000 (N0047-0251-60); scored 1 grain tablets in bottles of 100 (N0047-0252-51) and 1000 (N0047-0252-60); 1½ grain tablets in bottles of 100 (N0047-0253-51) and 1000 (N0047-0253-60); scored 2 grain tablets in bottles of 100 (N0047-0257-51); 3 grain tablets in bottles of 100 (N0047-0254-51) and 1000 (N0047-0254-60); scored 5 grain tablets in bottles of 100 (N0047-0255-51) and 1000 (N0047-0255-60). Full information is available on request. P-GP-51 4/c

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Dyrenium®

brand of **triamterene**

Potassium-sparing adjunct to furosemide in cardiac edema.

Now in 50 mg. and 100 mg. capsules.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid-induced edema, idiopathic edema, edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.

Contraindications: Severe or progressive kidney disease or dysfunction (possible exception: nephrosis). Severe hepatic disease. Pre-existing elevated serum potassium. Hypersensitivity to the drug. Continued use in developing hyperkalemia. Do not give potassium supplements, either by drug or by diet.

Warnings: Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically, especially in the elderly, diabetics, and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F) and spironolactone are not usually used concurrently, if they are, however, frequent serum potassium determinations are required.

Precautions: If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy, withdraw gradually because of possible rebound kaliuresis.

Adverse Reactions: Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash.

Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

Supplied: 50 mg. capsules, in bottles of 100; 100 mg. capsules in bottles of 100, in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630

Subsidiary of SmithKline Corporation

Auscultation

Don't listen standing on your head. The most experienced cardiologists have long realized that getting both the patient and the physician in a comfortable, relaxed position is a requirement for the best auscultatory results. The reason for this is unknown, but it is remarkable how often one sees a patient in an awkward, uncomfortable position with the physician twisted and contorted, trying to hear something that can be heard only with difficulty, even under the best possible circumstances. (James V. Warren: 10 Tips to Help you Make Better Use of Your Stethoscope. *Medical Opinion* [Nov] 1974, pgs. 31, 35-36.)

School Lunch

Variation of nutrient levels among schools with the same brands, same suppliers, and same supervision dramatically demonstrates the effects of handling. Temperature of cold storage and air circulation during storage are examples of factors which may be poorly controlled, taking their toll of certain labile nutrients before employees ever handle food. Prepeeling vegetables, cooking items a few hours before needed and reheating, and using equipment made of catalytic materials are not uncommon. There are undoubtedly many nutrient-destructive practices of which we are not aware. (Mary K. Head.: Nutrient Losses in Institutional Food Handling. *Jl. Am. Dietetic Assn.* [Oct] 1974, pgs. 423-427.)

Society Recycled

In outlining his social and scientific expectations for the 1990's, Nobel Laureate Glenn Seaborg sees a more highly disciplined and *straight* society to emerge as a result of reactions to critical materials shortages and technological failures. He believes the energy crisis is only the "forerunner of a number of situations that will change attitudes, behavior, and institutions."

Dr. Seaborg said that man's initial response of conservation and cooperation will result in improved self-pride, ingenuity, and creativity. He stated that even though society will be living in a more crowded, complex environment, a turning from the self-indulgent, somewhat neurotic characteristics that earmark the '70's, will make it "mentally and physically healthier."

"We will be creating a 'recycle society'," he said, "and never again live in a society where so much is taken for granted. (*Medical News Report* 6:9 [March 4] 1974, pg. 2).

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.



Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measure

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastr secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine help to control the acid-spasm-pain complex

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine
(propantheline bromide)

a good option in peptic ulcer



Pro-Banthine®
brand of
propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

SEARLE **Searle & Co.**
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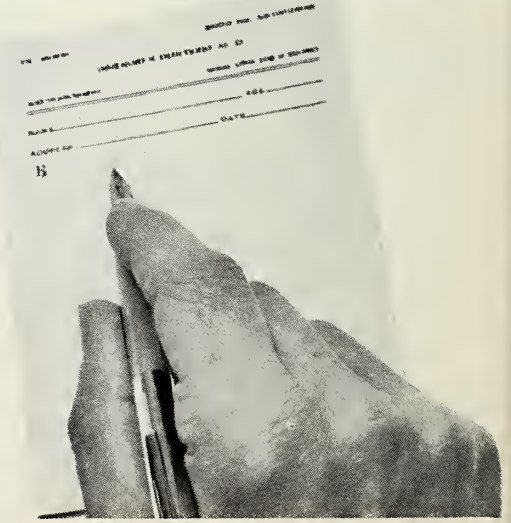
Twenty-eight Clinics for Crippled Children Listed for May

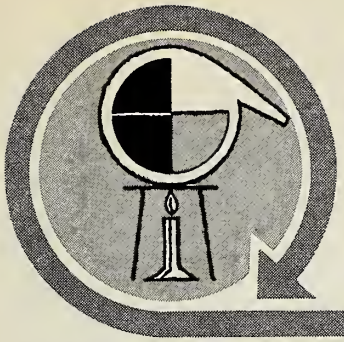
Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The Division will conduct twenty general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be six special clinics for children with cardiac conditions, and two for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

May 1 Sterling—Sterling Community Hospital
May 1 Effingham—St. Anthony Memorial Hospital
May 1 Lake County Cardiac—Victory Memorial Hospital
May 6 E. St. Louis—Christian Welfare Hospital
May 7 Hinsdale—Hinsdale Sanitarium
May 8 Macomb—McDonough District Hospital
May 8 Springfield—St. John's Hospital
May 9 Chicago Heights Cardiac—St. James Hospital
May 12 Peoria Cardiac—St. Francis Children's Hospital
May 13 Peoria—St. Francis Children's Hospital
May 14 Rock Island Cerebral Palsy—Foundation for Crippled Children and Adults
May 14 Champaign-Urbana—McKinley Hospital
May 14 Joliet—St. Joseph's Hospital
May 15 Rockford—Rockford Memorial Hospital
May 15 Pittsfield—Illini Hospital
May 15 Elmhurst Cardiac—Memorial Hospital of DuPage County
May 19 Peoria Cardiac—St. Francis Children's Hospital
May 20 E. St. Louis—Christian Welfare Hospital
May 20 Rock Island—Moline Public Hospital
May 20 Decatur—Decatur Memorial Hospital
May 21 Springfield Pediatric Neurology—Diocesan Center
May 21 Evergreen Park—Little Company of Mary Hospital
May 22 Anna—Union County Hospital
May 23 Chicago Heights Cardiac—St. James Hospital
May 27 Peoria—St. Francis Children's Hospital
May 28 Centralia—St. Mary's Hospital
May 28 Elgin—Sherman Hospital
May 28 Chicago Heights—St. James Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

Bioequivalence





new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

VERMOX — Anthelmintic Rx

Manufacturer:	Ortho Pharmaceutical Corp.
Nonproprietary Name:	Mebenazole
Indications:	Infections caused by pinworms, round worms, common hookworms and American hookworms.
Contraindications:	Do not use during pregnancy.
Dosage:	Children and adults: one tablet in the morning and evening on three successive days. In enterobiasis: one single tablet.
Supplied:	Tablets, 100 mg.

DUPLICATE SINGLE DRUGS

AMEN — Hormones Progesterones Rx

Manufacturer:	Carnrick Laboratories
Nonproprietary Name:	Medroxyprogesterone Acetate
Indications:	Secondary amenorrhea, abnormal uterine bleeding.
Contraindications:	Thrombophlebitis, liver dysfunction or disease, known or suspected malignancy of the breast, undiagnosed vaginal bleeding.
Dosage:	Follow instruction in package insert.
Supplied:	Tablets, 10 mg.

DECADERM — Topical Steroid Rx

Manufacturer:	Merck Sharp & Dohme
Nonproprietary Name:	Dexamethasone
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Those usual with corticosteroids.
Dosage:	Apply to affected areas t.i.d. or q.i.d.
Supplied:	Tubes, 15 and 30 Gm. 0.1%.

HYDRAZOL — Diuretic Rx

Manufacturer:	Softcon Products, Div., Warner-Lambert Company
Nonproprietary Name:	Acetazolamide
Indications:	Adjunctive treatment of chronic simple glaucoma, secondary glaucoma and preoperatively in acute angle glaucoma.
Contraindications:	See package insert.
Dosage:	250 to 1,000 mg. p.d. in divided doses.
Supplied:	Tablets, 250 mg.

ISO-BID — Coronary Vasodilator Rx

Manufacturer:	Geriatric Pharmaceutical Corp.
Nonproprietary Name:	Isosorbide Dinitrate
Indications:	For relief of angina pectoris, also useful in prophylactic treatment.
Precautions:	Use with caution in patients with glaucoma.
Dosage:	One capsule every 12 hours on an empty stomach. Not intended for sublingual use.

COMBINATION PRODUCTS

MODICON — Contraceptive Rx

Manufacturer:	Ortho Pharmaceutical Corp.
Composition:	Ethinyl estradiol 0.035 mg. Norethindrone 0.5 mg.
Indications:	Oral contraception
Precautions:	Those usual with contraceptive preparations.
Dosage:	Initially: One tablet daily from the 5th through 24th day of menstrual cycle. Subsequent cycles: No tablets for seven days, then one tablet for 21 days.
Supplied:	21-day Dialpack

NEW DOSAGE FORMS

MISTURA — Eye Preparations Rx

Ophthalmic Sprays

Manufacturer:	Lederle Laboratories
Form of Presentation:	Spray delivery system for administration of precise amounts of drugs for topical ophthalmic use.
Indications:	*Chronic, simple open angle glaucoma:* MISTURA P—Pilocarpine HCl 0.5; 1; 2; 3; 4 per cent Rx MISTURA E—Epinephrine HCl 0.25; 0.5; 1; 2 per cent Rx MISTURA C—Carbachol 0.75; 1.5; and 3 per cent Rx *Decongestive Therapy* MISTURA D—Phenylephrine HCl 0.12 per cent o.t.c. MISTURA D.Zn—Phenylephrine HCl 0.12 per cent o.t.c. Zinc Sulfate 0.25 per cent
Supplied:	Dispensing bottles, 15cc

Must vasodilators and therapy for other diseases come into conflict?



not if the vasodilator is

VASODILAN®
(ISOXSUPRINE HCl)

the compatible vasodilator... no treatment conflicts reported

The cerebral or peripheral vascular disease patient often has coexisting disease[1] which calls for another drug along with his vasodilator. It may be a hypoglycemic, miotic, antihypertensive, diuretic, anticoagulant, corticosteroid, or coronary vasodilator.

Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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Editorials



Renew Your Membership in Life

Vigorous, enthusiastic men and women enjoy life's challenges. They are too busy living each day to the fullest to brood; they often carry their vitality and zest into old age. Perhaps the adage, "A person dies when he no longer contributes to life" is applicable.

The critical period of men seems to set in when they reach their late fifties or early sixties. Many decide they are "over the hill" and become so depressed that they count the years until retirement. These individuals are existing, not living, and although the change of life often is blamed, it rarely is the real cause of their problems.

Quite often, successful professionals, including physicians, lawyers, and executives, lose interest and find themselves in a rut at this age. Sometimes the depression starts when they realize they have gone as far as they can in the business world and they lack the energy and ambition to try something new.

Soon they begin to refuse civic and professional responsibilities and excuse their apathetic outlook with, "I've done my share, let a younger man do his part."

Egos are bruised when the man realizes that in order to maintain his business or professional standing, he must compete with less experienced, but success-oriented men who are ambitious and energetic.

The older man makes a mistake when he withdraws or disengages himself from his associates. He compounds the problem when he no longer sees fit to attend meetings, conventions, or seminars that would bring him up to date with the latest advances in his field.

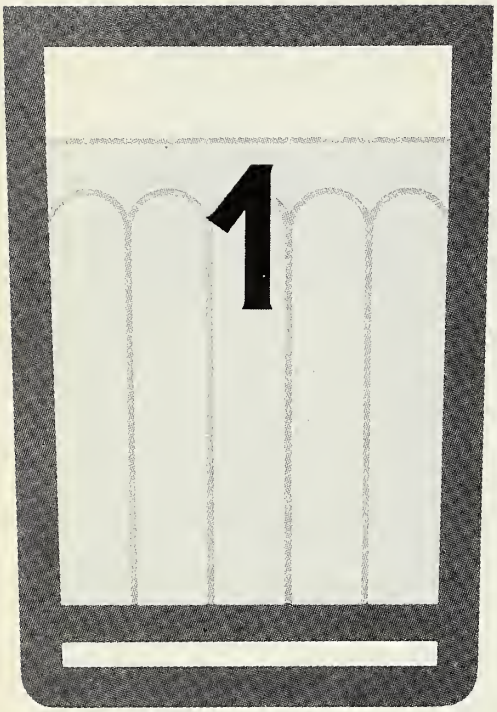
The solution is simple: He must get involved and renew his membership in life. Rekindling one's interest in life may take force and determinations, but the rewards are well worth the effort.

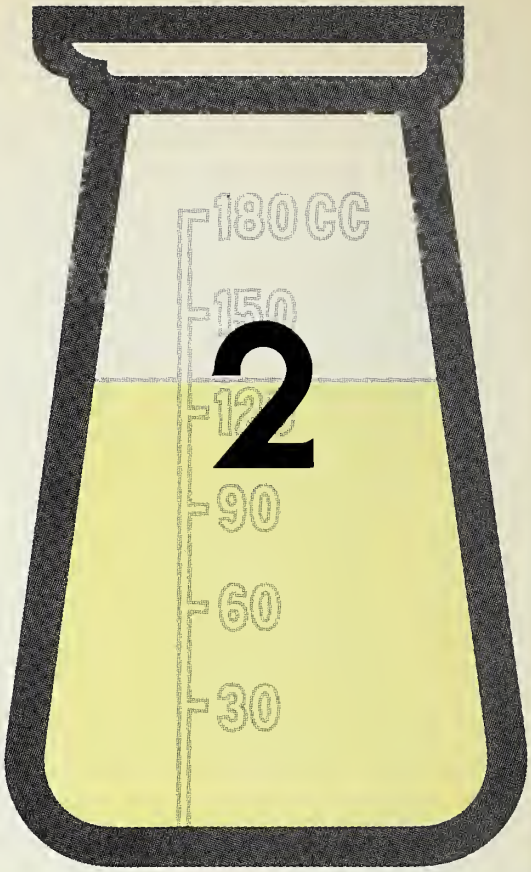
One way to stay mentally alive is to keep up with current events. Calculate how many professional years are left and make tentative plans for every day of it.

Some retired physicians have learned enough about meteorology to predict the weather; others have become fine locksmiths, and still others spend their time pursuing artistic endeavors. So if you have a hobby, refine it; if you don't have a hobby, cultivate one.

Give Father Time a wide berth by becoming active and alive again.

T. R. Van Dellen, M.D.
Editor





Adequate fluid intake

Frequent voiding

IMJ
Illinois Medical Journal
Vol. 147, No. 4, April, 1975

MEDICINE 2001 A.D.

By Louis D. Boshes, M.D./Chicago

"Men Love to Wonder—that is the seat of our science"
Ralph Waldo Emerson, American Essayist and Poet, 1803-1882

In humility and awe, I act as an oracle to inform you of what medical philosophy breakthroughs might be expected by 2001 A.D. Medicine carries a dual tradition. Helping the sick has always been the foremost responsibility of the physician. This duty as symbolized in the ancient Greek and Roman cults of Aesculapius demanded that the first duty of the physician was to furnish aid for the welfare of his patient by whatever means within his power. The other tradition has been concerned with the whole community. This direction can be traced very easily through the cult of Aegea which flourished not only in Athens, but also in Mosaic times and was concerned with sanitary regulations in cities and in military camps.

It is my belief that by 2001 A.D. we will follow the cult exemplified by Aesculapius. What may be ongoing at that time will be considered as old fashioned today, for I predict throughout this entire scenario that there will be a greater public demand for that necessary attention to aspects of both good and ill health. In fact, this will be the most important factor challenging the health care delivery system 25 years hence.

Each of us is well aware of medical costs and this will continue to be a problem even at that time, particularly in view of substantial technological advances which will undoubtedly occur. Superimposed upon this will be cultural changes, attitudinal changes, and value system changes. By the same token, population and age distribution will play a cogent role because the population of our world is expected to reach more than seven billion. In this country our population should at least double. A breakdown of the population figure in 2001 A.D. shows that the group of individuals who are 25-34 years old today will increase twenty million. The group which is between 25-45 years old today, will decline whereas the older group who may survive in 2001 A.D. will only grow by a few million. Accordingly, both the older and middle age groups will still be concerned with decline in energy and verility. There will be a greater emphasis on physical and mental fitness.

Regretfully and from a pessimistic point of view, I must predict that there will occur a lessening of concern for ailments which generally bring an individual to a physician. The average person will place more reliance on self care and medication and acceptance of management by spiritual, nature and organic healers, and any other exotic back-to-nature cults may cause more problems. Being pessimistic I must predict that the direction of medical education today may lead to the output of too many ill-trained physicians and other paramedical professionals.

All management will be under the scope of governmental business and other agencies which will control people as well as medications used by this group.

LOUIS D. BOSHES, M.D., is a clinical professor of neurology attending in the Research and Education Hospital, and director of the Consultation Clinic for Epilepsy at the University of Illinois. He is also senior attending neurologist and psychiatrist, and chief of the Neurology Clinics at the Michael Reese Hospital and Medical Center.



What changes can we expect to see in the more important aspects or areas of medical concern? What are some of the predictions for 2001 A.D.? I will touch on some areas where there have been beginnings and where some projections can be made.

Artificial Organs:

More transplants than ever before are in the offing. Kidneys, livers, lungs, pancreas, colons, stomachs, bladders and even brains may be successfully transplanted by 2001 A.D.

Automation:

It is my belief that physicians will never become obsolete, but computers will become as common in doctor's offices as stethoscopes are at the present time. There may even be *housecalls* via two-way television particularly in rural communities. The specialist will be available for instantaneous consultations via television or telemetry.

Body Farming:

By 2001 A.D. I am sure our social mores, attitudes, ethical and moral values will have changed to such a degree that "organ farming" will not be looked upon with horror. The idea of a body being dismembered and the parts stored for future use will be an everyday event. There will be better methods for organ preservation. Transportation from central core zones to special sites will be routine procedure. Even "farming" of a brain and its transplantation by 2001 A.D. cannot be ruled out. Since by 2001 A.D., there will be development in terms of pharmacology to advance the knowledge of the function of mind and behavior in terms of conscious and subconscious, there may be a capability to effect brain transplants.

Cancer:

Almost every type of cancer may be controlled to some degree by chemicals, radiation, or surgery. Most important will be the ability to track down those last few remaining cells that can start new colonies. These nests will be attacked through computer and mathematical procedures.

Cardiovascular Disease:

Hardening of the arteries, the pathological basis for heart attacks, will become largely preventable, or at least reversed through the use of certain drugs. Strokes and kidney disease will also be forestalled through similar advances in research.

Common Colds:

Most likely, the common cold will be controlled through discoveries within the discipline of immunology.

Community Medicine:

The physician of the future will be involved with dozens of ancillary workers in the management of a patient. Although a certain amount of specialization will persist, there will be more generalists, and family practitioners will once again return to that friendly and rewarding environment called "Family Practice."

The physician will play an active role in striking at the very roots of illness through preventative medicine and health education as well as in active participation in the life of his community. Financing mechanisms will put a premium on preventable medicine and health education. Obviously the Federal Government will at that time have a greater role in the matter of management of illness than it has in the present.

Dental Disease:

In all likelihood, dental caries will be found to be an infection and decay will be controlled by vaccines that will have been created for this common problem. More dental work will be done in the laboratory than in the patient, because a tooth may be extracted, rapidly repaired in the laboratory, and reinserted. Missing teeth will be replaced by synthetic teeth.

Dermatology:

As long as there is skin, there will be dermatologists. The skin, which is the largest organ of the body, will continue to be subjected to the detrimental effects of occupation and environmental hazards.

Ear, Nose and Throat:

Placement of hearing aids virtually within the skull instead of within the ear, or on the outside of the ear, has been started. Synthetic vocal cords and even complete larynx reconstruction is in the offing.

Epilepsy:

At the present time, there are some two dozen drugs available for the control of seizures. Patients in this country, roughly 4½ million, obtain about 70% control by these drugs today. By 2001 it is hoped that one or two drugs will handle every type of epileptic problem and that these drugs will be entirely anticonvulsive, nonsedative, and nontoxic.

Gastrointestinal:

Peptic ulcers should become a rarity, for physicians are beginning to consider an ulcer as an autoimmune illness for which there will be developed an antidote.

Genetics:

Better understanding of genetics will give an ability to institute prophylactic measures to correct chromosomal abnormalities which have an important correlation to illness. These abnormalities have an important ramification in the area of behavioral science as well as in physiological sciences.

Geriatrics:

Geriatrics will become a highly developed specialty and since there is no question of the conquest of cancer, cardiovascular, and cerebral vascular disease, there will be an extended and lengthened quality of life. Our nation may become a gerontocracy, and life within it will be lengthened by various means.

Heredity:

Congenital defects due to heredity or abnormal development will be treated prophylactically intrauterine, before the infant is born. Epidemiology will be closely correlated to heredity in specific situations.

Hospitals:

These will be built for specific illnesses and staffed mostly by specialists in such illnesses. Outlying hospitals will handle only less serious cases. Costs of construction will increase markedly because of future new features to include moveable walls. Only ceilings will be immovable, and floors will be adjustable to meet specific needs. Portable intensive care units will be plugged in anywhere. Hotel units will be available for the families of patients.

Immunology:

Autoimmune states in specific illnesses such as thyroiditis, colitis, asthma, arthritis, will respond to special agents which will have an important effect upon these illnesses.

Internal Medicine:

It is my belief that the internist will become more closely associated with the patient as well as with his family. There will be less strict specialization which will be replaced by more broad coverage by the internist. There will be a greater mechanization and computerization particularly in performing and recording laboratory data, electrocardiographic, hemodynamic and pulmonary functioning.

Life Creation:

Certainly there will be a creation or synthesis of the living fetus. The only question is whether or not this is necessary.

Medical Education:

Students entering medical school will be selected very carefully in terms of their humanistic attitudes. The technological knowledge available in terms of life and death will make it necessary that students be educated to make decisions about whether life is to be preserved or not prolonged. There will be more women in medicine than ever before. We will attempt to reach the levels of other countries in privileges offered women entering medical schools.

Neurology:

The neurologist will be separated farther and farther from his patient by increased needs for refresher courses. Post-graduate education will demand an immediate amount of record keeping for reports that will have to be made. There will be considerable computer techniques developed which will be applied to Neurology resulting in prompter and more accurate diagnostic formulations. Drug therapy will include better management of seizures, and chronic headaches. The etiology of illnesses such as multiple sclerosis, amyotrophic lateral sclerosis, and the management of other related mysterious illnesses will be known. We may prove that degenerative diseases like Jacob-Creutzfeldt Disease and subacute sclerosing panencephalitis are due to slowly acting viruses.

Neurosurgery:

Much of the pain in the future may be controlled by electrical stimulation. I believe that dorsal column stimulators and peripheral nerve stimulators will be developed to such a point that they will be used to relieve pain without actually being implanted in the spinal cord. Percutaneous techniques of cordotomy and surgical procedures for trigeminal neurolgia will be advanced further. Electrical stimulation of the occipital cortex will enable the blind to develop vision. Malignant brain tumors such as glioblastomas will respond to medication. I do not believe there will be too many major changes in aneurysmal surgery and endarterectomies. How-

ever, we will learn more about spasms so that aneurysms can be operated upon. A better understanding of cerebrovascular physiology will overt the severe and often unpredictable complication of such surgery.

As far as surgery for the convulsive state is concerned, or even for so-called "aggressive behavior," I am sure that both of these conditions will be treated better with specific medications than with surgery. We will learn more about intractable seizures by 2001 A.D. through better knowledge of metabolism hormonal function and imbalance of andiuretic hormones. There will be a better approach to the management of the paraplegic and/or quadraplegic. New methodology and new thoughts in physiology, plus the creation of a new instrumentation will help some paraplegics. There will be a more refined cooling technique and new steroid techniques to help these individuals.

Nursing:

Nursing, as we know it today, will not exist by 2001 A.D. Instead there will be "New Health Professionals." The new health professional will work at the side of the doctor in many situations. More people will be attracted to Nursing in 2001 A.D. because of the extended duties and professional status.

Nutrition:

By 2001 A.D. with the population rising to seven billion, nutrition will be extremely important. New methods of recycling foods and better means of preparation will eliminate hunger. Foods will be stored in areas like the Arctic or the Antarctic for possible periods of famine.

Obstetrics:

Babies will be ordered from laboratories where fetuses will be incubated in 260 days rather than the usual 280 days. Prenatal care, toxemia of pregnancy, Caesarean sections and Placentaprevia will be a thing of the past.

Ophthalmology:

Malignancies will be removed from the eye without removal of the entire organ. Better methods for the detection of hereditary diseases will be achieved through genetic counselling. The eye specialist will be able to place filter paper to the eye, remove tears, and make genetic studies. New methodology for cataract removal, detached retinae and the management of diabetic neutopathy, will eliminate many of these conditions.

Orthopedics:

There will be transplatation of fingers, arms, toes, and legs. These limbs will be worked by small motors which will be placed within circuits that are generated electronically through impulses from the brain. There will also be considerable development in artificial joints for the shoulder, elbow, wrist, and hands.

Psychiatry:

I believe the provisions in psychiatric services will be very comprehensive and will be delivered through conglomerates of psychiatrists and behavioral scientists working in some type of group comprehensive care system. Psychiatric services will be based on breakthroughs in the field of biochemistry of the brain and behavior research. This will change the behavior of individuals consistent with their own distress about such behavior. Genetic counselling and preventive psychiatry will teach families about growth and development.

New coalitions in the field of behavioral sciences will provide for the working together of geneticists, psychiatrists, pharmacologists, and biologists, at a clinical level. By the turn of the next century, schizophrenia and some of its forms will be recognized by objective diagnostic techniques and treated by new pharmacal therapies. The same progress will take place in research on affective disorders. Learning and development will therefore be of central concern. I have discussed the future of psychiatry in terms of a broader sociopolitical context. Psychiatry in its various practices has been influenced, not only by advances in molecular biology, genetics, and neurophysiology, but also by the accelerating forces of social change. Social psychiatrists and the psychiatrist' involvement in group phenomenon will predominate. There are many plans ahead for change in psychiatric education. Psychiatry will again be at the center of things as it was in the Egyptian Temples of healing 3000 years ago.

Plastic Surgery:

Plastic surgery will become one of the leading surgical specialties by 2001 A.D. because of continued desire to overcome human defects.

Sex:

Liberation of attitudes toward sex will continue. Pre-marital sex will be widespread, and commune living will be popular. However, there will be a heavy price to pay for the increased

(Continued on page 378)

CONDYLOMATA ACUMINATA:
Treatment by Autogenous Vaccine

By Richard J. Ablin, Ph.D. and William W. Curtis, M.D./Springfield

A description of the preparation and administration of autogenous vaccine and the possible mechanism(s) of its action in the immunotherapeutic treatment of patients with Condylomata acuminata *are presented as an alternative means of treatment in recalcitrant cases or as an adjunct to conventional therapy*

Condylomata acuminata is generally thought to be of viral etiology. The relevance of this disease is particularly evident from the recent report by Cook and co-workers of the increased incidence of papillomatosis of the larynx in children of pregnant women with C. acuminata at the time of delivery.[1] The failure of some patients to respond favorably to conventional therapy, e.g., podophyllin, excision and/or fulguration and antibiotics as well as the sometimes deleterious complications of such therapy, prompted us to re-evaluate the efficacy of immunotherapy through the use of autogenous vaccine as initially reported by Biberstein[2] and more recently by Powell, Pollard and Jinkins.[3] The interest expressed in our recent brief communication[4] suggested to us that it would be desirable to present a detailed account of our methodology, recommendations and the possible mechanism (s) of action of the immunotherapeutic treatment of C. acuminata through the utilization of an autogenous vaccine.

Materials and Methods

Preparation of Autogenous Vaccine

Tissue is obtained (a minimum of 2-5 grams of tissue is recommended for preparation of an adequate amount of vaccine for an initial series of injections) in chilled sterile saline (0.15M NaCl) at 4°C from the patient, in the present case at the time of Caesarean section, washed in sterile balanced salt solution (Medium 199, Grand Island Biological Company, Grand Island, New York) and trimmed of any extraneous matter. Representative specimens are saved and prepared accordingly for routine histologic confirmation of the diagnosis.

Care must be taken at all times to carry out the entire preparation of the vaccine under sterile conditions. As such this requires pre-sterilization of all materials, e.g., centrifuge tubes. The tissue is then weighed and cut into small pieces and homogenized in a blender (Sorvall Omni-Mixer) for 3-5 minutes in 9 parts weight/volume of cold saline/1 part tissue in a container immersed in an ice bath. The resulting homogenate is subjected to four freeze-thaw cycles in a solid CO_2-alcohol bath and centrifuged at 5,000 rev/min for 10 min. at 4°C in a Sorvall refrigerated centrifuge. The supernate is withdrawn and placed in a water bath at 56°C for 60 min. and then centrifuged at 10,000 rev/min. for 10 min. at 4°C to clarify the solution of any precipitate which may have formed.

This clarified supernate is then aspirated into a sterile plastic syringe and as an additional precautionary measure against bacterial contamination it is filtered/sterilized through an 0.45μ Millipore membrane. Absence of bacterial contamination is confirmed by inoculation of 0.1 ml of vaccine into 10 ml of Brain Heart Infusion (Difco Laboratories, Detroit, Michigan) for the presence of aerobic contamination and 0.1 ml of vaccine into Pre-reduced Cooked Meat Media (Scott Laboratories, Inc., Fiskeville, Rhode Island) for the presence of anaerobic contaminates. Samples taken from these cultures at one and five days are gram-stained and cultured on Blood Agar. In the absence of growth after 5 days, the vaccine is considered to be sterile and is suitable for skin-testing and subsequent administration. If growth is present the vaccine is re-filtered and re-tested for sterility. The vaccine may be either stored, frozen or lyophilized for later reconstitution with sterile water.

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WILLIAM W. CURTIS, M.D. is a clinical associate in the Department of Obstetrics and Gynecology at Southern Illinois University School of Medicine, Springfield.

If preparation at the time of collection of tissue is not feasible, the tissue may be immediately frozen in liquid nitrogen and stored at −20°C until a time convenient for preparation.

Administration

To avoid the possibility of any untoward reaction the prospective patient should be skin-tested with approximately 0.25-0.50 ml of the autogenous vaccine. In the absence of reaction*, 0.5-1.0 ml of the vaccine may be administered to the patient subcutaneously at weekly intervals with routine histologic follow-up, at least two weeks following the initial injection and thereafter monthly. In the event of overt progression within 2 to 4 weeks or stasis at 8 to 10 weeks post-therapy other modes of therapy should be considered in place of immunotherapy or as adjunctive.

Exemplary Case History

A 26-year-old caucasian female was first seen July 20, 1971 for pregnancy. Her last period had been May 8. Her periods were regular. She had been a diabetic since the age of six. Routine examination in September disclosed a Monilia infection and perineal warts were evident. Conservative treatment with Sulfa cream and Gentian Violet were initiated at this time and continued until the patient entered the hospital to be delivered. Estriol on October 23 was 14.2 mg per 24 hrs. and on January 5 was 15.6 mg per 24 hrs. On January 17 she was admitted to the hospital and a Caesarean section was performed 72 hours later. The infant died and a ureterocaesarean section and tubal ligation was carried out.

Following a negative skin-test with an autogenous vaccine prepared as described above from the genital warts removed at the time of Caesarean section, the patient received 0.2 ml weekly subcutaneous injections of vaccine for a period of seven weeks. In the present case, only 0.2 ml of vaccine per week was used due to the limited amount of material available. Approximately two months following the initial injection, the perineal warts were much improved as was her discharge and irritation. Presently, all lesions have disappeared with no recurrence.

Two other female patients treated in a similar manner with autogenous vaccine have responded favorably (C. E. Burpo, D. J. Kroe, and R. G. Trinity, personal communication) as well patients with persistent and/or recurrent anal *C. acuminata* (H. Abcarian, personal communication).

**If the prospective patient has any previous history indicating a familial or acquired aberration of immunologic responsiveness, this individual's present immunologic competence should, even in the absence of a positive reaction, be evaluated as recently suggested for precautionary measures.*[5]

Discussion

Immunotherapy for the treatment of warts of the genital areas, such as C. acuminata, by autogenous vaccine was described as early as 1944 by Biberstein.[2] However, until the recent report by Powell and co-workers[3] this modality of therapy had apparently fallen into disuse. Immunotherapy, although less of a conservative approach to the treatment of condylomata, should be considered, particularly in recalcitrant cases, or a recurrence and proliferation following conventional therapy occurs.

Alternatively, in cases involving giant condyloma's, consideration should be given to employment of chemoimmunotherapy, that is initial treatment with 5 per cent topical 5-fluorouracil ointment (5-FU) followed by injection with autogenous vaccine. The rationale in combining chemo- and immunotherapy is that initial treatment with 5-FU, a fluorinated pyrimidine which inhibits DNA synthesis, may achieve reduction in the size of the initial lesion, thereby rendering it more amenable to immunotherapy.

In conclusion, some consideration should be given to the mechanism (s) of action of autogenous vaccination in the treatment of C acuminata. Recently it has been suggested by Nel and Fourie that as the potential antigens (viral?) which are present within the lesion may be sequestered (isolated) from potential antibody forming cells that the opportunity of the host to develop an immunologic response as in other infectious diseases is perhaps severely limited.[6] Alternatively, the host's ability to manifest a response of sufficient magnitude, probably through mechanisms involving cell-mediated immunity, whereby cytotoxic lymphocytes lead to the rejection of foreign or aberrant cell lines, may be impaired. In this regard, e.g., increased levels of gestational hormones, present during pregnancy, a period in which the incidence of condylomata has been shown to be elevated[3] may be one of many factors responsible for this impairment of host resistance.[7,8]

Thus, it would appear that injection of autogenous vaccine results in direct stimulation or augmentation of the host's mechanisms of resistance. However, in instances where a patient may fail to respond or may even exhibit progression of the extent of disease, this may be attributed to the presence of preformed circulating antibodies. Based upon present knowledge such antibodies could conceivably exert a blocking effect thereby interferring with the action of specifically stimulated cytotoxic killer lymphocytes and perhaps even result in enhancement.[9]

(Continued on page 346)

Respiratory Burns

By John E. Martin, M.D./Chicago

Smoke inhalation and respiratory burns are common events. The diagnosis of a respiratory burn is often most difficult for a physician seeing a patient shortly after smoke inhalation and/or exposure to heat. There are often no physical findings and the patient is asymptomatic. The question of whether to hospitalize or not, treatment plan if there are symptoms, and course the patient will follow are pertinent to the initial assessment. Based on a series from Grady Memorial Hospital, an attempt is made to answer these questions.[1]

A careful history as to the type of exposure will help assess the likelihood that a patient has suffered a respiratory injury. Wet heat (e.g. steam) inflicts more damage than dry heat of the same temperature. When combined with smoke however, the damage of dry heat is comparable to that of wet heat.[2] An explosion in a closed area is of greater significance than one in an open area. Three criteria may be used in determining the likelihood of a respiratory burn: (1) flame burns about the face, (2) singed areas about the face, lips, mucous membranes of pharynx, and (3) external burns inflicted in a closed area. When all three are present, the probability of a respiratory burn approaches one-hundred percent, with two of the three about sixty percent, and with one about thirty percent.[2] Cough, soot in the sputum or pharyngeal area and complaints of shortness of breath tend to parallel the above criteria. Arterial blood gas determination is necessary and carboxyhaemoglobin determinations useful in the assessment of a patient with respiratory burns.[3] Subclinical ventilation-perfusion abnormalities and intra-pulmonary shunting will manifest themselves by low oxygen tensions. Carbon monoxide formed secondary to incomplete combustion may be of such magnitude as to decrease significantly the oxygen capacity of hemoglobin without cyanosis and in fact, with the "cherry-red" color of the patient, giving false assurance.

Staging

The clinical stages of a respiratory burn are inversely related to the severity of the burn; that is to say, the more severe the burn, the earlier will be the signs or symptoms. A useful staging is that of Stone et al who used three stages.[1]

A. Stage I, may occur any time from five minutes to thirty-six hours after injury and is characterized by respiratory insufficiency. Bronchospasm, cyanosis, restlessness (probably due to hypoxia), hoarseness, cough, elevated CO_2 tension may all be present. The cough is usually non-productive and the chest X-ray is negative. This clinical picture is associated with the most severe burns.

B. Stage II, occurs from six to seventy-two hours after injury and is the picture of pulmonary edema with the characteristic X-ray changes and frothy sputum, which may be pink. The edema may be the result of the primary injury to the lung, iatrogenic fluid overloading or heart failure.

C. Stage III, is the bronchopneumonic stage and occurs anywhere from three to ten days after injury. The organisms most often found are staph and pseudomonas, although there have been no reports of anerobic cultures taken in patients with respiratory burns. The X-ray is compatible with the clinical picture.[2,4,5]

Management

The management of the injury is dependent upon the stage at which the patient is encountered. Patients in Stage I will go through Stages II and III. Those patients with the least severe injuries will need to be followed for a significant period of time as their symptoms may not occur for many hours to days. All patients should probably be hospitalized for a minimum of twenty-four hours for observation.

There is a limited number of positive actions that can be taken in treating patients in Stage I. The most important are (1) relieve bronchospasm, (2) give high humidity, and (3) maintain arterial blood oxygen. Conventional broncho-

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dilators should be used and if they are not successful, steroids in single doses (e.g. prednisone 100-200 mg) are indicated and may be repeated as often as necessary to control the spasm. Prophylactic or constant use of steroids is associated with an increased mortality secondary to suppression of the host defenses with death caused by overwhelming infection. High humidity may be given in a tent, croupette, or by aerosol and supplemental oxygen by cannula, mask, or aerosol.

Stage II is best treated by prevention. Using the minimum amount of electrolyte solution, using colloid solutions, and attempting to keep the urine out-put in a barely acceptable range (40-50 cc hours), decreases the likelihood of pulmonary edema. Prophylactic digitilization should be undertaken if there is any question of impending heart failure or in the elderly if there is no contraindication. Unless there is strong evidence for upper airway obstruction, tracheostomy should be avoided as it appears to precipitate the occurrence of pulmonary edema, probably on a neurological basis. It is one of the significant factors affecting mortality in an adverse manner.[1,4]

Stage III is characterized by watchful waiting, daily sputum cultures with sensitivities and with evidence of pulmonary sepsis, treatment with the specific antibiotic. Inhalation therapy equipment may be essential in the management of patients with respiratory burns but it is a potential source of serious infection and meticulous attention must be paid to maintenance of the equipment. An attempt should be made to distinguish between colonization which will occur uniformly and sepsis. A rising temperature curve and elevated white count will aid in this distinction. Prophylactic treatment with antibiotics is associated with a high mortality and over-growth of resistant organisms.

Following the above guidelines, Stone and his colleagues[2] were able to reduce the mortality over a five year period from sixty-five percent to twenty-two percent. The greatest reduction came in Stage I and was associated with the use of high humidity, the selected use of corticosteroids, and avoidance, whenever possible, of tracheostomy. ◄

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Condylomata Acuminata

(Continued from page 344)

Therefore, as previously mentioned, extreme caution should be exercised in selecting this type of therapy. Above all, utilization of autogenous vaccines in patients possessing severe aberrations of immunologic responsiveness may be hazardous and is not to be recommended. In this regard it would be of interest, if not a must, to evaluate pre- and post-therapy serum specimens for the presence of antibodies to antigens in the autogenous vaccine. Initially high antibody titres might reflect the presence of preformed *'blocking factors'* and thus serve as a poor prognosticator for immunotherapy, thereby dictating utilization of other modes of therapy. ◄

Acknowledgement

Acknowledgement is made to G. R. Bruns and P. F. Deutsch for assistance in preparation of vaccines and to Alton J. Morris, M.D. for directing our attention to earlier studies of the use of vaccines.

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Complications of Indwelling Venous Catheters

By William T. Meszaros, M.D. and Yammanuru Ramulu, M.D./Chicago

There has recently been a great increase in the use of indwelling venous catheters. These catheters are used for central venous pressure (CVP) monitoring, and for infusion of drugs and intravenous fluids. There are numerous complications which result from the use of these catheters (Table I). Many of these complications can be either diagnosed or suspected from the radiologic examination. This report presents four cases which demonstrate the value of the radiologic examination.

Case Reports

Case I: A 17-year-old male was admitted to the hospital following a gunshot wound of the chest and abdomen. Extensive surgery was required to repair injuries to the kidney and colon. In the postoperative period, CVP catheter insertion via the right internal jugular vein was attempted without success. When the catheter was removed it was noted that the tip of the catheter was lost. A chest roentgenogram revealed the catheter to be in the soft tissues of the neck (Fig. 1). Removal of the catheter fragment was not attempted because of the critical condition of the patient.

This case illustrates catheter breakage without emoblism.

Case II: An 18-year-old male was admitted to the hospital because of alcoholism and drug overdosage. The patient was semi-conscious and somewhat uncooperative. A catheter was inserted in the left antecubital vein for intravenous fluid administration. The patient flexed his arm and broke off the catheter tip. Palpation of the arm revealed no evidence of a catheter fragment.

The catheter tip was believed to be somewhere in the systemic venous circulation, but a catheter fragment could not be demonstrated on portable X-ray examination of the arm and chest. On the following day the patient was brought to the X-ray department. During chest fluoroscopy, the catheter was found in a branch of the left pulmonary artery. This was documented by spot and routine chest films (Fig. 2). Thoracotomy was performed, and the catheter was removed through a tiny incision in the lower lobe branch of the left pulmonary artery. The catheter fragment measured 13.2 cms. in length and was filled with clots. The patient recovered completely and was discharged 10 days later.

This case illustrates the problem of catheter embolism.

Case III: A 69-year-old male was admitted to the intensive care unit with congestive heart failure, diabetes and severe dehydration. A CVP catheter was inserted into the left internal jugular vein to

Table I
Complications of Indwelling Venous Catheters[1-15]

I. Local Complications
 A. Infection (cellulitis)
 B. Venous thrombosis
 C. Thrombophlebitis
 D. Subcutaneous hematoma
 E. Venous perforation
 F. Arterial puncture
 G. Brachial plexus palsy
 H. Catheter breakage
II. Distant Complications
 A. Cardiac complications
 1. Cardiac perforation
 2. Catheter embolism
 3. Intracardiac thrombus
 4. Arrhythmia
 5. Intrapericardial infusion
 6. Tamponade
 B. Pulmonary (chest) complications
 1. Pneumothorax
 2. Hemothorax
 3. Intrapleural infusion
 4. Mediastinal infusion
 5. Pulmonary thromboembolism
 6. Pulmonary air embolism
 C. Septicemia
 D. Death



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YAMMANURU RAMULU, M.D. is an Associate Attending Radiologist at St. Mary of Nazareth Hospital. He was a General Radiology Resident at Illinois Masonic Hospital previously.

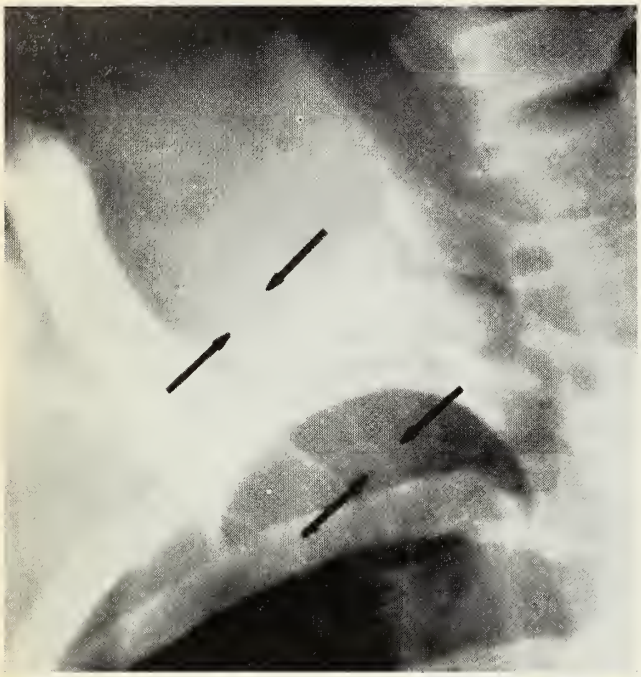


Figure 1. Case I. Right apical portion of chest roentgenogram showing catheter fragment (arrows) in subcutaneous tissues.

treat the severe dehydration. Intravenous fluids were rapidly infused through the catheter, 4 liters being administered in a 24-hour interval. In spite of the fluids the patient became worse, with increasing dyspnea. A portable supine roentgenogram of the chest was obtained, which showed a large left pleural effusion (Fig. 3, B). This fluid was not present on a roentgenogram made 24 hours earlier, before the insertion of the CVP catheter (Fig. 3, A). The catheter was immediately withdrawn. Thoracentesis was performed and 3300 cc. of fluid were removed from the left chest.

This case illustrates intrapleural infusion of fluids due to an extravascular location of the catheter tip.

Case IV: A 64-year-old male had a myocardial infarction which produced cardiac arrest. He was successfully revived, and in the post-arrest period a CVP catheter was introduced, presumably into the left jugular vein. However, the patient's clinical progress was unsatisfactory. During the next 8 hours, dyspnea and chest pain increased and CVP readings were difficult to obtain. The clinician suspected improper positioning of the CVP catheter. However, an anteroposterior view of the chest showed the catheter apparently in normal position. Ten cc. of 50% sodium diatrizoate were then injected into the catheter. The contrast material entered and opacified the mediastinum, indicating extravascular mediastinal location of the catheter tip (Fig. 4). The catheter was removed immediately. The patient's condition improved and he survived.

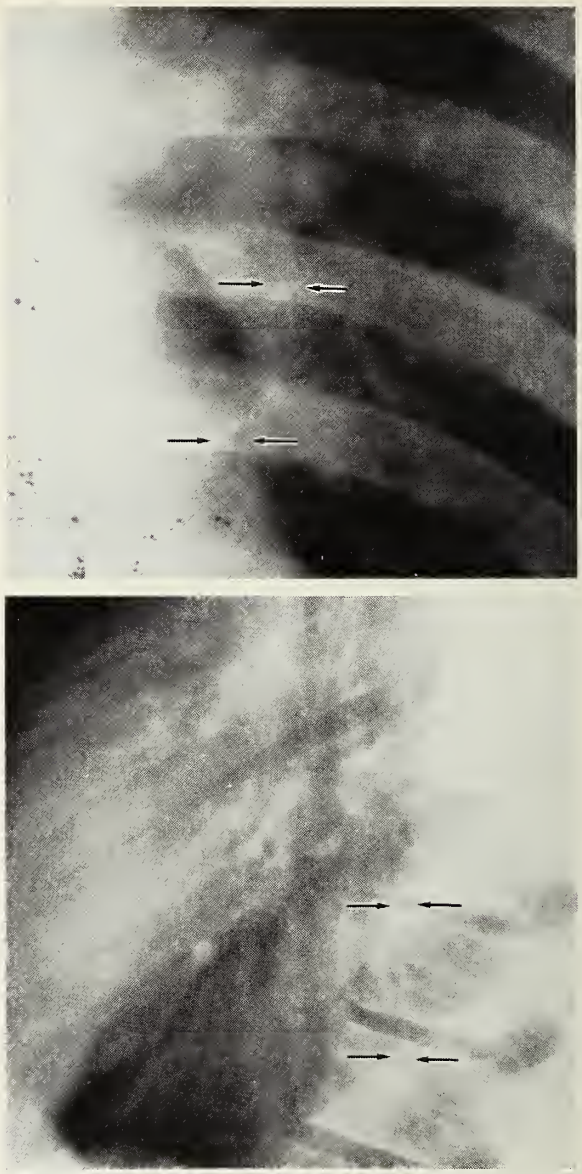


Figure 2. Case II. Frontal (A) and lateral (B) views of the left lower lung field showing a catheter fragment (arrows) in the pulmonary artery branch to the left lower lobe.

This case demonstrates the difficulty of determining the position of the catheter tip on a plain roentgenogram and illustrates the value of injecting contrast material to localize the catheter position.

Discussion

The patient who needs an indwelling venous catheter generally has complex medical or sur-

gical problems. Complications due to the catheter may further burden the cardiorespiratory system and occasionally these complications may be lethal. It is therefore important for the clinician to be aware of the nature of these complications and their early recognition.

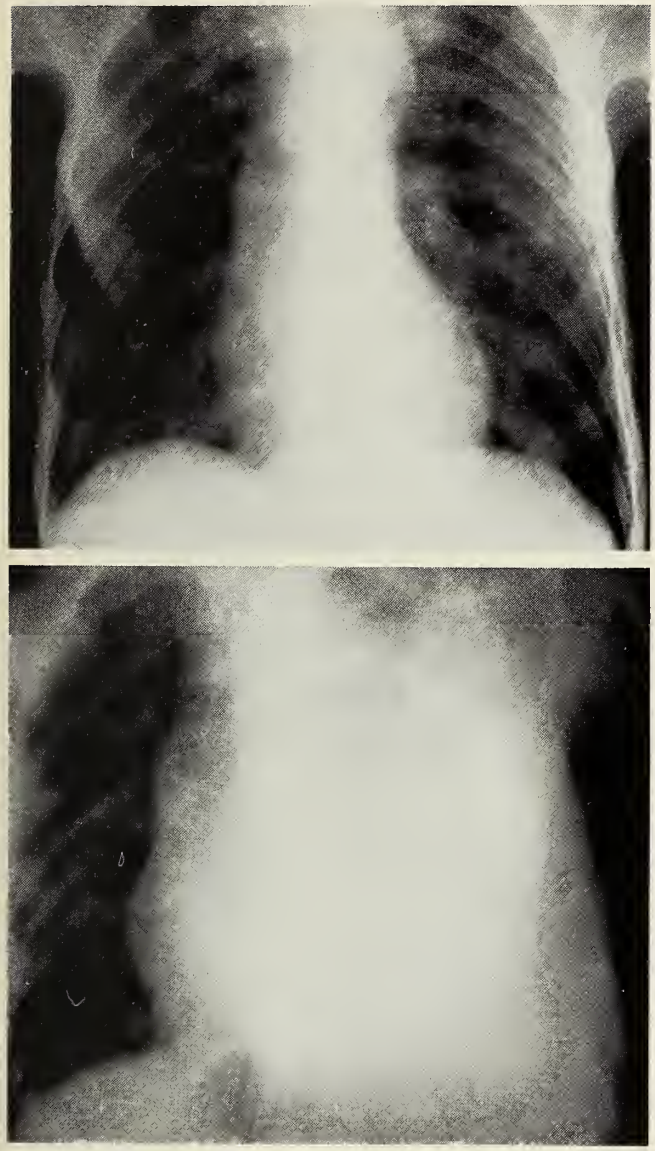


Figure 3. Case III. A. No evidence of fluid prior to catheter insertion. B. Massive left pleural effusion due to intrapleural infusion secondary to an extravascular location of the catheter tip.

Diagnosis of Complications

Most (but not all) complications of indwelling venous catheters are produced by two major factors, both of which produce roentgenologic abnormalities: (1) breakage of the catheter tip and (2) improper position of the tip.

Breakage of the catheter tip. When the clinician suspects that the catheter tip has been broken during removal, a careful search of the bed and floor is indicated. If the catheter tip is not found, a roentgenologic examination of the area of the catheter insertion is made, because the catheter may be entirely subcutaneous (Fig. 1). If the catheter is thus not located, roentgen studies are made of the entire area from the site of catheter insertion to the heart and lungs. Visualization of the catheter fragment is difficult. Portable technique is unsatisfactory. In general, the best visualization is obtained by using Bucky technique and the shortest possible exposure time. When the catheter is located, removal is desirable to prevent infection, thrombosis, cardiac perforation or death. The catheter fragment may be removed surgically or by snaring through a non-surgical percutaneous catheterization.[1,2]

Improper position of the catheter tip. An intracardiac position of the catheter may produce several complications, including cardiac arrhythmia and intracardiac thrombus. Roentgenologically, a rapid widening of the cardiac shadow suggests cardiac perforation, intrapericardial infusion and cardiac tamponade.

Pulmonary complications include thromboembolism, with roentgen signs of pulmonary embolism and infarction. Numerous pulmonary complications arise from perforation of the vein by the catheter tip. Roentgen manifestations of



Figure 4. Case IV. Extravasation of contrast material into mediastinum (lower arrows) following injection through CVP catheter. Upper arrows indicate catheter.

pneumothorax may be obvious. Mediastinal infusion of fluids leads to mediastinal widening. Hemothorax or intrapleural infusion produce roentgen evidence of pleural effusion (Fig. 3, B).

Radiologic demonstration of the location of the CVP catheter is essential to minimize complications from the catheter. The tip of the catheter should be in the superior vena cava.

CVP catheters are usually faintly radiopaque and therefore the position of the catheter can often be identified roentgenologically. However, occasionally the exact position cannot be assessed due to the limited value of the bedside roentgenographic technique. Sometimes the catheter may appear to be in the proper position but is still outside the vascular system. In obese individuals location of the catheter without added contrast material can be very difficult. Therefore, catheterography is indicated in any case in which there is doubt regarding the position of the CVP catheter.

A single anteroposterior film is made, usually at the bedside, while the contrast is being injected into the CVP catheter. Approximately 10 to 20 cc of 50% sodium diatrizoate is used. The contrast is injected manually as rapidly as possible, and the roentgenographic exposure is made just before the completion of the injection.

When the catheter is outside the vascular system, the contrast material enters the soft tissues, producing a streaky appearance. The outline of the contrast material does not correspond to a blood vessel. The contrast material lingers in the extravascular area for a prolonged period.

Prevention of Complications

A radiopaque catheter should be used, but unusually thick and stiff catheters should be avoided since they may be prone to produce local thrombosis.[3]

Local thrombosis and thrombophlebitis are also more likely when a small vein is used.[3] This explains the popularity of the external jugular approach. The subclavian route should be avoided because of the possibility of pneumothorax.[4]

The CVP catheter tip should be in the superior vena cava, not the right atrium. An intracardiac catheter tip may produce cardiac arrhythmia, intracardiac thrombus, or perforation. Perforation is not necessarily immediate, and may occur days later after repeated cardiac contraction against the catheter tip, particularly if it has been wedged.

Pulmonary air embolism can be prevented by the use of a dependent catheter loop.[4]

Breakage of the catheter tip is an extremely important problem, since it may lead to embolism of the catheter fragment. The needle bevel cover should be properly secured over the cutting tip. Proper taping of the external portion of the catheter is of prime importance since this will prevent a broken catheter tip from slipping into the vein.[2] Breakage occurs by a shearing action of the needle on the catheter, particularly during insertion and removal. During removal, the needle and catheter should be withdrawn as a unit. If the catheter is withdrawn first, the needle point may cut the catheter.

Summary

There are numerous complications from indwelling venous catheters. The roentgen examination is of great value to the clinician for the recognition of these complications.

Four cases are presented which demonstrate the value of the X-ray examination. The cases illustrate catheter breakage (Case I), catheter embolism (Case II), intrapleural infusion (Case III) and extravascular location of the catheter tip (Case IV). ◄

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Retinal Detachment and Toxemia of Pregnancy

By Lee Vida, M.D./New Orleans, La.

Since Von Graefe initially reported in 1855 that toxemia may have associated serous retinal detachment,[1] it has been determined that such retinal detachments occur at a rate of about 1% in cases of toxemia and 10% in eclampsia.[2] The progression of the secondary diastolic hypertension may trigger serous retinal or choroidal detachment with edema, hemorrhages and exudates, which probably derive from both the retina and choroid.[3] Because retinal holes are rarely present, the detachment is termed non-rhegmatogenous.

Re-attachment often occurs spontaneously. However the general prognosis in regard to vision depends upon the residual changes left by the accompanying retinopathy, which may include retinal pigmentary degeneration and even a secondary optic atrophy following papilledema.[4]

Case Report

A pregnant, 20-year-old Negro woman was presented to the L.S.U. Eye Clinic, Charity Hospital, New Orleans, on July 7, 1972, complaining of blurred vision for three days' duration. She had attended pre-natal clinic once, several months earlier. Within the previous month she noticed swelling of her hands, face and feet. She denied having headaches recently and there was no history of any previous significant illness, surgery or allergies. The patient was Gravida 2, Para 1, LMP November 23, 1971, EDC August 30, 1972, and had an uncomplicated pregnancy and delivery in 1970, although she gained 40 pounds during that previous gestation.

Ophthalmological examination revealed an uncorrected visual acuity of finger counting at six feet in each eye. Intraocular tension was normal O.U. Pupils were normal in size and in reaction to light and a near visual target. There was mild hyperemia of the conjunctiva O.U., but corneas and anterior chambers were clear. The lids were moderately edematous. Dilated examination of the ocular fundi revealed extensive bilateral bullous serous retinal detachments with probable involvement of the macula, O.S.>O.D. There was well-developed papilledema with scattered cotton-wool exudates, but no hemorrhages. The retinal veins were dilated and tortuous and the arterioles narrowed without focal constriction. No retinal holes were present. The lens and vitreous were normal O.U.

Pertinent findings on general physical examination included blood pressure of 170/130, pulse 90, respiration 20, temperature 99.6°, moderate edema of hands, face and lower extremities, generalized hyperreflexia, clonus and mild mental confusion. Fetal size was estimated at 5-6 pounds and heart tones were 140/minute in the right lower abdomen.

A chest x-ray revealed cardiomegaly with some bilateral prominence of the pulmonary vasculature, but without pleural effusion or infiltrates. Laboratory studies included Hct 35; Hgb 11.4; WBC 9,600; VDRL negative; blood group A, Rh positive; +3 proteinuria; BUN 17 mgm %; FBS 79 mgm %; CO_2 17 m Eq/1; Creatinine 1.4 mgm %; Sodium 134 m Eq/1; Postassium 3.6 m Eq/1. ECG was normal.

The patient was treated with I.M. and I.V. magnesium sulfate; I.V. Unitensin, Valium, and Mannitol; and I.M. morphine sulfate and sodium luminal. Several hours after admission, labor was induced with intravenous pitocin. A spontaneous, uneventful vaginal delivery occurred eight hours later. The infant was a five pound, 11 ounce, viable male with a normal apgar rating.

Post partum the patient's blood pressure was intermittently elevated, requiring eight days of antihypertensive managment. Eventually she became normotensive without medication and her edema subsided.

The retinal detachments spontaneously regressed and were completely resolved three weeks

(Continued on page 353)



LEE VIDA, M.D., New Orleans, received his medical degree fram the University af Illinais and was in private general practice in Macamb, Ill., fram 1962 ta 1970. Presently he is completing aphthalmalagy training at Charity Haspital, Lauisiana State University Medical Center.

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A fifty-eight-year-old man came to the emergency room complaining of severe chest pain and diaphoresis. He had been treated for hypertension and hyperlipidemia for several years with good result. Despite warnings of his personal physician, he continued to smoke two packages of cigarettes per day. For three weeks prior to this ER visit, his chest pain had been more frequent, more severe, and had come with a lesser degree of exertion than previously. Now is was happening at rest. His physical examination only showed an atrial gallop and frequent premature beats. Figure 1 shows the ECG taken shortly after arrival in the ER. Figure 2 shows the ECG taken during a bout of chest pain at rest.

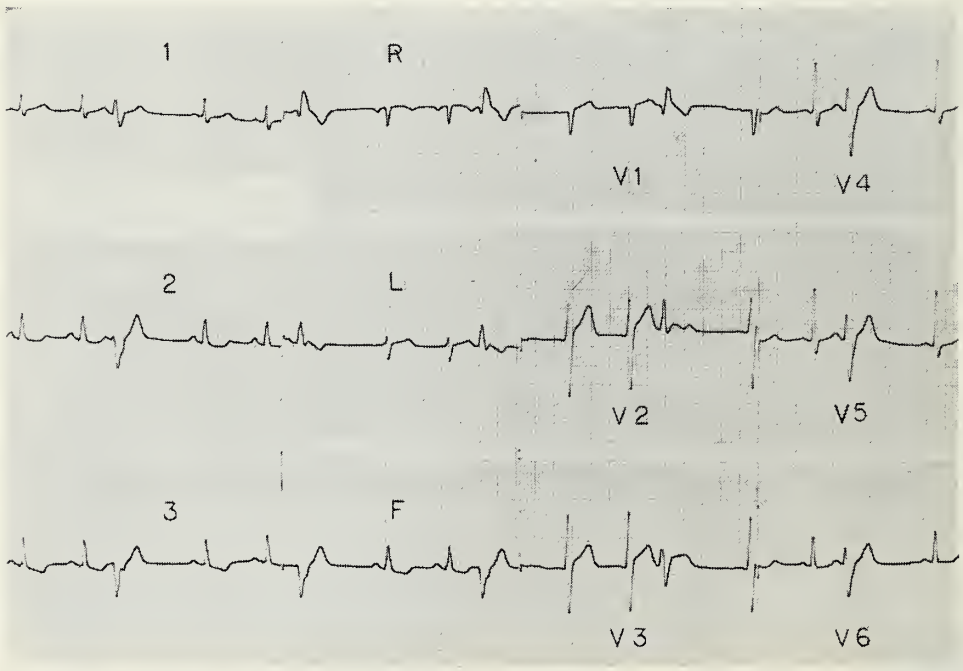


Fig. 1

Questions:

1. **The ECG in Figure 1 shows non-specific ST wave changes and frequent premature ventricular beats. The ECG in Figure 2 during chest pain shows:**

A. Complete left bundle branch block.
B. Complete right bundle branch block.
C. Idioventricular rhythm.
D. Premature ventricular beats.
E. ST segment elevation or a current of injury.

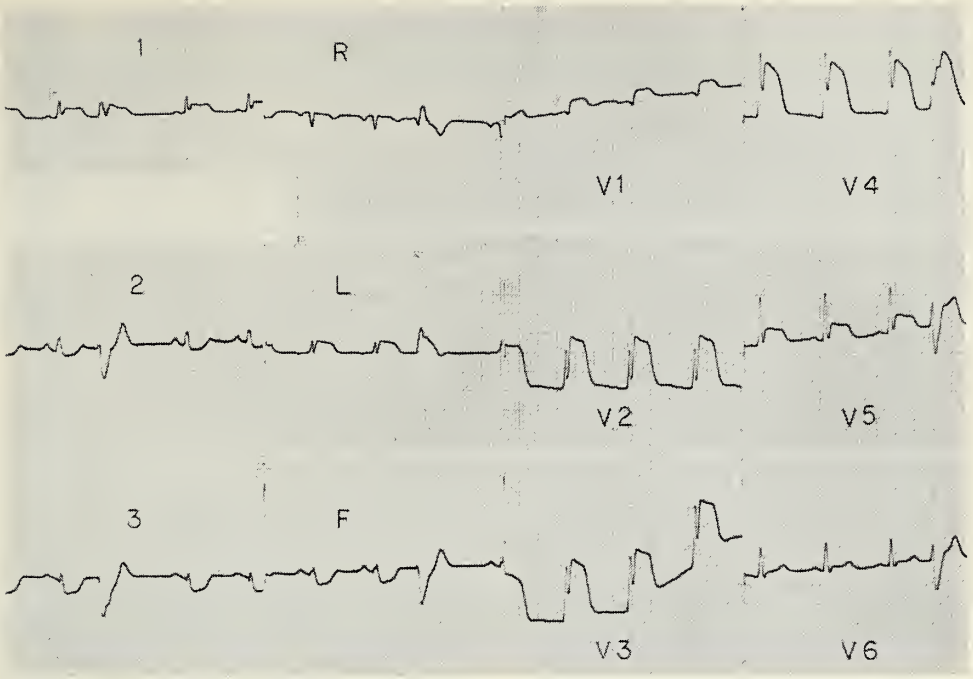


Fig. 2

2. Which of the following statements are true?

A. Propranolol and nitroglycerine could be used.

B. This could be called Prinzmetal's "variant" angina.

C. Coronary arteriography should be considered.

D. This clinical situation could be caused by fixed coronary artery obstructions or spasm of the coronary arteries.

E. Arrhythmias are frequently seen in this setting.

(Answers on page 380)

Retinal Detachment

(Continued from page 351)

post partum. Intravenous fluorescein retinal angiography revealed several focal detachments of the retinal pigment epithelium in the posterior pole of each eye. The papilledema and hypertensive retinopathy also had resolved. It was then discovered that the patient had previously uncorrected myopic astigmatism and refraction was O.D. $-1.00 + 1.50 \times 90°$ (20/30); O.S. $-1.00 + 1.75 \times 90°$ (20/40). Follow-up examinations revealed no recurrence of hypertension or ocular pathology.

Discussion

An unusual case is presented in which a patient with toxemia of pregnancy initially sought medical attention because of visual impairment due to bilateral serous retinal detachment. Resolution of the detachment occurred concomitantly with post partum recovery from the toxemia.

Visual complaints during pregnancy should be thoroughly evaluated by the attending physician or by appropriate consultation in order to exclude serious ocular pathology due to systemic disease. ◄

Acknowledgement

The author thanks Virginia Howard for her editorial assistance.

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surgical grand rounds

Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Passavant and Wesley Pavilions of the Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 8, 1973.

Ulcerative Colitis

Dr. Robert Ward: A 33-year-old woman entered the hospital April 1, 1973, complaining of diarrhea of twelve years duration. One year following the onset of 20-30 loose watery stools per day associated with abdominal cramps, the diagnosis of ulcerative colitis was established. The patient has continued to have about 10 watery stools per day for the past ten years which is now her only complaint. Nine years ago a brief trial of steroids had little effect. Two years ago she was noted to be anemic associated with an elevated serum alkaline phosphatase and increased brom sulfalein retention. A barium enema has been performed yearly for the past six years and proctoscopy every six months. Medications at the time of admission included ten Lomotil tablets per day, iron and birth control tablets. Social history, family history and review of systems were unremarkable. The patient appeared alert, well nourished and in no distress. Vital signs were normal. The physical examination was normal except for the presence of rectal stricture. Admission laboratory studies included a white blood cell count of 5,700 and hematocrit of 43. Urinalysis was normal. Serum electrolytes, BUN, SGOT, LDH and total bilirubin were normal. Alkaline phosphatase was 764. Serum albumin was 2.6 with a normal total protein. A chest X-ray and electrocardiogram were normal. Intravenous pyelogram was obtained and the recent barium enema was reviewed.

Dr. Leonid Calenoff: The chest radiograph and the intravenous urogram were normal. A review of the yearly barium enemas performed since 1969 showed typical changes of chronic ulcerative colitis. There was marked shortening of the colon which was located within the boundaries of the bony pelvis. In addition there was complete loss of the haustral markings and effacement of the mucosa. Numerous small radiolucencies were seen within the barium-filled colon which represented islands of regenerated mucosa. The ileocecal area was of particular interest because of the loss of the normal anatomical relationship. There was no ileocecal valve demonstrated as such and the terminal ileum had the same width as the colon. This is known as colonization of the terminal ileum. All barium enemas throughout the years showed very similar changes. The most recent examination (Fig. 1), shows no definite evidence of strictures or of a neoplastic process, and is typical of chronic ulcerative colitis.

Dr. Robert Ward: On April 3rd, two days following admission, the patient was taken to the operating room. Total colectomy, proctectomy and ileostomy were performed. Liver biopsy and tubal ligation were included during a procedure.



Figure 1. Radiologic study of colon demonstrates typical findings of chronic ulcerative colitis.

The post operative course was complicated by a peritoneal wound infection which was drained on the 8th postoperative day. The patient was discharged on the 18th postoperative day and has been well at home.

Dr. Joseph C. Sherrick: We first became aware of this case when we were asked to examine the ileum to make sure the affected area was completely excised. Figure 2 shows ileum with slightly thickened mucosal folds, infiltrated at the base with lymphocytes extending into the muscularis mucosa. These are the typical features of "backwash" ileitis associated with ulcerative colitis.



Figure 2. Ileum was found to have "backwash" ileitis.

The mucosa of the colon was thick and ulcerated, and there was marked polypoid hyperplasia of the mucosa. (Fig. 3) This change is probably related to repeated destruction and regeneration of the mucosa, and may possibly provide a background for the development of carcinoma.

Chronic ulcerative colitis is primarily a disease of the mucosa of the colon, and the hallmark of the disease is the crypt ulcer. (Fig. 4) The presence of crypt ulcers, mucosal hyperplasia, ulceration, lack of granulomas and lack of transmural involvement establish the diagnosis of chronic ulcerative colitis, and make it unlikely that the basic lesion is regional or granulomatous enteritis involving the colon.

In one part of the transverse colon, the wall of the colon was thick and there was a large irregular ulcer. Sections made from this ulcer showed a bizarre tumor (Fig. 5), composed of large cells arranged in irregular cords and tubule-like structures. In some areas, there were poorly formed glands, making possible a diagnosis of poorly differentiated adenocarcinoma. This tumor invaded deep into the muscularis but did not extend to the serosal surface of the colon. The lymph nodes did not contain tumor.



Figure 3. Section from colon demonstrates polypoid hyperplasia.

Patients with ulcerative colitis have a high incidence of carcinoma of the colon, and the type of tumor is often a poorly differentiated adenocarcinoma of unusual appearance. In most cases, the tumor is extensive by the time it is diagnosed, and the prognosis is poor. In this particular case, the limited extent of the tumor may possibly imply a better prognosis, although this may be negated by the lack of differentiation of the tumor.

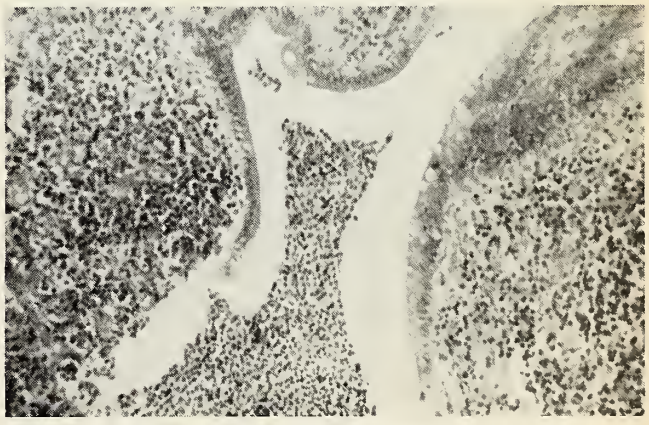


Figure 4. Crypt ulcer is shown which is a typical early finding in chronic ulcerative colitis.

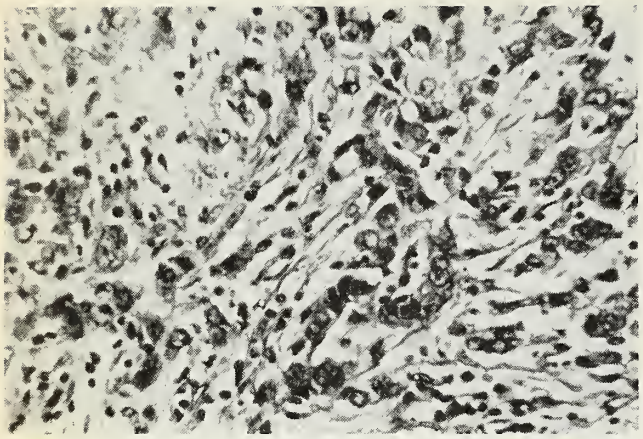


Figure 5. Section from colon shows poorly differentiated adenocarcinoma arising in chronic ulcerative colitis.

Dr. Marshall Sparberg: I have followed this patient for the past ten years. Although her clinical course has been relatively benign, her X-rays have continued to demonstrate severe disease. With the knowledge of the increased incidence of carcinoma after ten years of disease with total colon involvement, I urged her to consider surgical treatment. About the same time that we began to discuss prophylactic colectomy, her serum alkaline phosphatase level began to rise. This is not unusual in long-standing colitis and represents a pericholonangitis. When severe enough, it can lead to cirrhosis. Subsequently, her BSP has been elevated as high as 18%. Thus, because of the fear of the development of both carcinoma and cirrhosis, we finally persuaded this patient to accept colectomy. Despite the duration of her disease and the marked changes demonstrated by X-ray examination, she was quite healthy looking, tolerated her 8 or 10 bowel movements quite well, was mildly anemic but responded well to iron therapy. So, in every sense, this was considered to be an elective prophylactic colectomy.

Dr. Stuart M. Poticha: Chronic non-specific ulcerative colitis is a disease of the colon that does not involve the ileum, per se, and this patient had a classical history with proctoscopic and X-ray evidence of typical ulcerative colitis. Why then was the terminal ileum involved? Known as "backwash" ileitis, it involves the first few inches of terminal ileum and is really a response to a disease in the colon. In this patient, at the time of operation, the terminal ileum was thickened. We selected a site approximately six inches from the ileocecal valve to transect the ileum. Frozen section was performed on the ileum at the site of division and showed inflammation. Therefore, an additional five inches of terminal ileum was resected.

The problem of carcinoma in patients with ulcerative colitis is one that has interested surgeons and pathologists since 1928 when the relationship was first described by Bargen. When I first met this patient, her comments to me were, "I really don't understand why I'm having this operation now because I never felt better in my life." Her comments dramatically illustrate the danger of an insidious carcinoma of the colon developing in a patient with ulcerative colitis. The incidence of carcinoma in ulcerative colitis varies tremendously depending upon the series. Most medical series report an incidence of between 2 and 5% which usually includes cases of left sided mild colitis in which carcinoma rarely occurs. In surgical series, the incidence is usually reported somewhere between 5 and 8%, while in autopsy series, it is usually about 15%. However, if one selects only those patients who have had ulcerative colitis longer than ten years, then the incidence rises tremendously. Both Lyons and Cattel have reported an incidence as high as 25% in these patients.

McDaugal has stated that if the patient has had ulcerative colitis for ten years, their chance of developing carcinoma is about 30 times the chance of carcinoma developing in the normal patient. For those who agree with Mr. Aylet from England who believes in leaving the rectum behind in ulcerative colitis, the chance of developing a carcinoma in such a retained rectum is about 65 times as high as in the normal rectum. The problem becomes one of how to predict which patients should have their colons removed prophylactically because of the danger of carcinoma. There are some criteria that we can use. In the first place, the risk of carcinoma is much higher in patients who have had continuous symptoms, and in whom there is involvement of the entire colon rather than segmental involvement. Furthermore, there are some early pathologic changes which were beautifully illustrated by Dr. Sherrick. Dysplasia, hypochromatism of the nuclei and budding of the glands should be considered premalignant changes and, when present on rectal biopsy, should be an indication for prophylactic colectomy. The overall prognosis in patients with carcinoma of the colon complicating ulcerative colitis is dismal. As you know, the prognosis of carcinoma of the colon is somewhere between 40 and 60% five year survival depending upon the stage of the carcinoma. Most series report approximately a 20% five year survival when ulcerative colitis is involved. ◄

Busulfan Toxicity

By Howard Vernof, M.D., Harry J. Miller, M.D., and Malcolm V. Vye, M.D./Evanston

Busulfan is an alkylating agent used primarily in the treatment of chronic granulocytic leukemia. The case of an elderly man who was treated with busulfan for chronic granulocytic leukemia and who developed pulmonary fibrosis, an adrenal insufficiency-like syndrome, and prostatic carcinoma is reported. The scope of busulfan toxicity as well as a review of the pertinent literature is discussed.

A thoroughgoing investigation culminating in open lung biopsy to determine the nature of his pulmonary problem is emphasized. We conclude that this approach is essential in such cases in order to establish the correct diagnosis and institute appropriate therapy.

Case History

The patient, an 85-year-old white male, was admitted to Evanston Hospital for the first time in April, 1967, with a six-year history of leucocytosis. The leucocyte count was 144,750/cu mm with 23 segs, 31 bands, 23 metamyelocytes, 7 myelocytes, 8 lymphocytes, 3 blasts, 1 monocyte, 3 eosinophils, and 1 basophil. The platelet count was 129,000/cu mm. The chest X-ray was normal. (Fig. 1) A bone marrow aspirate was compatible with chronic granulocytic leukemia. The Philadelphia chromosome was present. The patient was given busulfan in a dose of 4 mgms per day. On August 19, 1970 he entered the hospital for evaluation of dysuria and prostatic enlargement. He had been taking busulfan intermittently since April of 1967. His leucocyte count was 10,300/cu mm and the platelet count was 59,000/cu mm. Needle biopsy of the prostate revealed adenocarcinoma. Cobalt-60 teletherapy to a dose of 5,600 rads was given through three portals to the perineum. This reduced the prostate to normal size and relieved the dysuria. He has had no further difficulty in this regard.

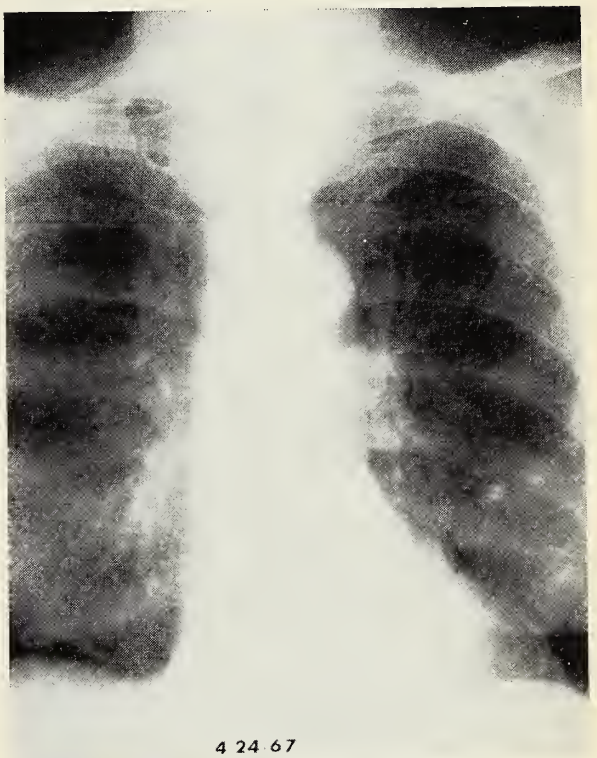


Figure 1. Chest x-ray taken during the initial admission reveals essentially clear lung fields.

On July 30, 1972, he was re-admitted to the hospital with a one week history of dyspnea on exertion. He was taking prednisone, 20 mgms/day; allopurinol, 100 mgms/day and isoxsuprine HCl (Vasodilan), 30 mgms/day. He had last taken busulfan, 4 mgms/day, from March 15, 1972 to April 8, 1972. Prednisone had been started on May 17, 1972, to treat thrombocy-



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MALCOLM VYE, M.D. is an attending physician in the Department of Pathology and Director of the Hematology Laboratory at Evanston Hospital. He is also an Assistant Professor of Pathology at Northwestern University School of Medicine. Dr. Vye is a member of the American Association of Clinical Pathology and is presently Treasurer of the Chicago Pathological Society.

topenia. Petechiae were present on the chest, back, abdomen and extremities. Examination of the lungs revealed bilateral crepitation with occasional wheezing. The liver edge was palpable 12 cm below the right costal margin. The spleen was not palpable and there was no lymphadenopathy. The hemoglobin was 11.8 gm/dl, with a hematocrit of 36.0%. The leucocyte count was 11,200/cu mm with a differential of 84 segs, 3 bands, 1 metamyelocyte, 7 lymphocytes, 1 eosinophil and 2 basophils. The platelet count was 18,000/cu mm. The serum muramidase was 20 microgram/ml (normal 1-10 microgram/ml). The 24 hour urinary muramidase was 1.0 microgram/ml (normal 0 to 2 microgram/ml). The serum vitamin B_{12} concentration and unsaturated B_{12} binding capacity were normal. The admission chest X-ray revealed prominent basilar lung markings with suspected congestive heart failure superimposed upon chronic fibrosis.

Platelet transfusions were given to correct the thrombocytopenia. Bilateral basal crepitation persisted during the hospital stay and were unresponsive to a trial of furosemide. Sputum cultures grew Klebsiella pneumonia. A trial of tetracycline therapy did not change his physical findings or symptoms. Sputum cultures later revealed a growth of β-hemolytic Streptococcus and Staphylococcus aureus, coagulase positive. Tetracycline was stopped and he was given gentamicin sulfate for six days. There was no objective or subjective response. A chest X-ray was again interpreted as diffuse bilateral interstitial pneumonitis superimposed on pre-existing chronic fibrosis. (Fig. 2) On the fifteenth day of hospitalization, he complained of extreme weakness and lethargy. Serum electrolytes revealed completely normal values: sodium 137 mEq/L, potassium, 5.4 mEq/L, chloride 102 mEq/L, and CO_2 combining power 24 mEq/L. The BUN was 12 mgm/dl and creatinine 1.6 mgm/dl.

An ACTH stimulation test using 40 units of ACTH infused intravenously over an 8 hour period for 3 consecutive days was performed. Baseline plasma corticoids revealed a morning value of 17.6 mcg/24 hrs (normal 5-22 mcg/24 hrs), and an afternoon value of 21.5 mcg/24 hrs. After 3 days of stimulation with ACTH the morning plasma corticoids measured 27.7 mcg/24 hrs and the afternoon 13.6 mcg/24 hrs. Despite the normal adrenal function, he was given dexamethasone 0.75 mgms daily with marked clinical improvement. Sputum cytology did not reveal tumor cells. Histological studies of the patient's serum were unrevealing except for a moderate number of Candida albicans. Fungal blood cultures were negative. Arterial blood gases were

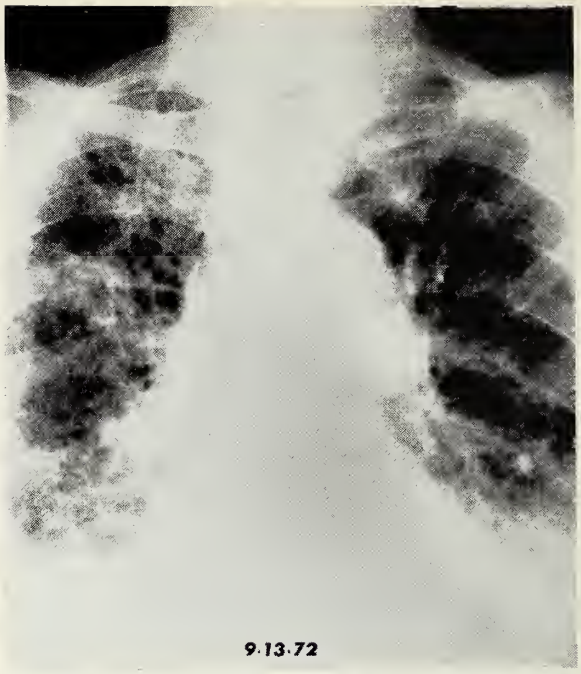


Figure 2. Chest x-ray taken during the second admission (5½ years after Fig. 1) reveals a diffuse irregular increase in density of both lung fields, with the right more severely affected. The diameter of the heart has also increased.

pO_2 34.6 mm Hg, pCO_2 15.7 mm Hg, and pH 7.5. Pulmonary function studies were consistent with restrictive lung disease.

To help clarify this complicated case, the following questions were formulated:

1. Was this a case of busulfan lung?
2. Was there a superimposed infection with an opportunistic organism such as Candida albicans or Pneumocystis carinii?
3. Were the pulmonary problems related to chronic interstitial fibrosis or to leukemic infiltration?

In an attempt to answer these questions, bronchoscopy and bronchial brushings were done using the technique described by Fry and Manalo-Estrella.[1] These were not diagnostic.

On September 14, 1972, an open lung biopsy was performed. Histologic sections of the lung revealed extensive interstitial fibrosis with severe obliteration of the normal architecture. (Fig. 3) The alveolar spaces were collapsed and in most areas were lined by hyperplastic cuboidal epithelium which exhibited an adenomatous pattern. (Fig. 4) The hyperplastic cuboidal epithelium was seen most strikingly in Epon embedded sections cut at 0.5 micron. (Fig. 5) Within the fibrocollagenous stroma were scattered chronic inflammatory cells which in some areas formed focal aggregates. The blood vessels were thickened, fibrotic and hyalinized. There was also

pleural thickening and evidence of pleural adhesions. Methenamine silver, Gridley and Gram stains for organisms were negative. The final histologic diagnosis was chronic interstitial pneumonitis consistent with pulmonary changes seen in busulfan therapy.

Arterial blood gases on September 20, 1972, revealed a pO_2 of 46 mm Hg, pCO_2 of 30 mm Hg and a pH of 7.47. The patient was discharged on continuous low-flow oxygen at a rate of 2 liters/minute (pO_2 at this rate of flow was 75 mm Hg, pCO_2 30.5 mm Hg, pH 7.49). Dexamethasone was changed to prednisone, 20 mgms every other day. He has done well at home since his discharge. He now requires oxygen supplementation only at night. A chest X-ray taken on January 31, 1973, shows partial resolution of the fibrosis. (Fig. 6)

Discussion

Busulfan(1-4, dimethanesulfonoxybutane) (Myleran) was first used to treat chronic granulocytic leukemia in 1953.[2] It prevents cell division by combining with the phosphate groups of DNA to cause denaturation. Bone marrow depression is the main toxic effect of the drug. Other side effects include gastrointestinal reactions, hepatic dysfunction, dermatitis, hyperpigmentation, alopecia, hyperuricemia, gynecomastia, testicular atrophy and amenorrhea.

In 1961, Oliner et al. reported interstitial pulmonary fibrosis in two patients with chronic granulocytic leukemia treated with busulfan.[4] Their patients complained of dyspnea, fever, weakness and weight loss. Dry crepitant rales were present in the lungs, and chest X-rays showed diffuse bilateral infiltrates with the appearance of an inflammatory reaction. Lung biopsy revealed diffuse interstitial pulmonary fibrosis. Therapy with corticosteroids resulted in radiological and subjective improvement in one patient and only partial subjective improvement in the other.

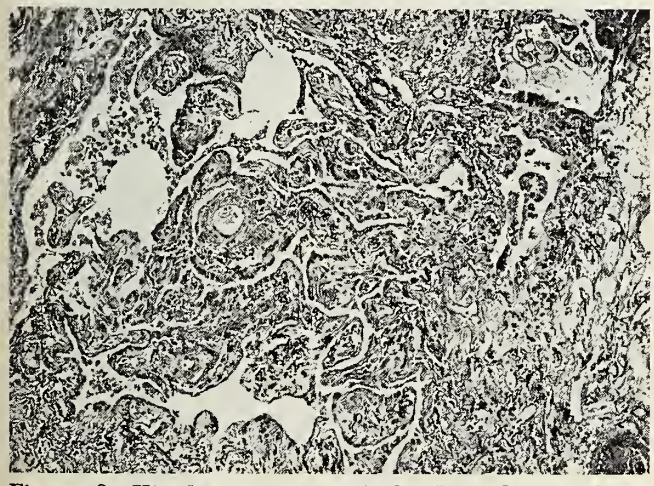


Figure 3. Histologic section of the lung biopsy shows marked alteraton of the pulmonary architecture by fibrous thickening of alveolar septa and desquamation of alveolar lining cells (hematoxylin & eosin stain).

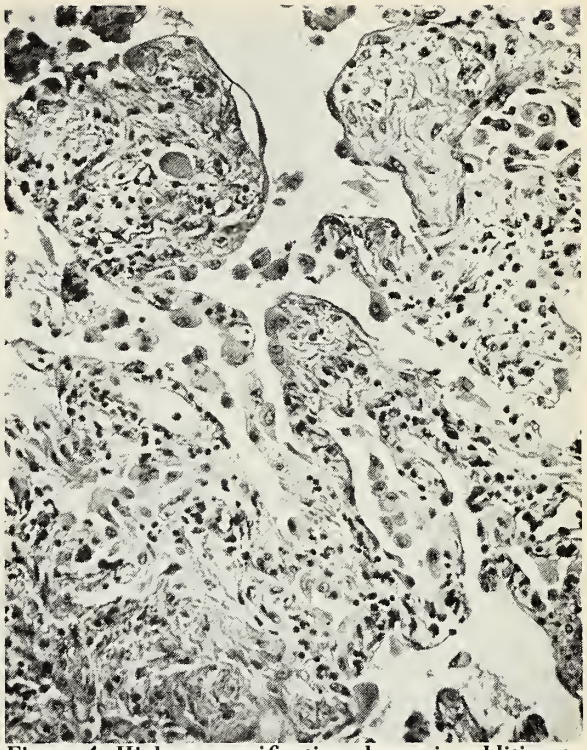


Figure 4. Higher magnification shows, in addition to fibrosis, a mild interstitial infiltrate of chronic inflammatory cells as well as hyperplasia of the alveolar lining cells (hematoxylin & eosin stain).

Included in the differential diagnosis of such pulmonary fibrosis were asbestosis, berylliosis, sarcoidosis, rheumatoid disease, scleroderma, idiopathic pulmonary vein obstruction, radiation pneumonitis, hexamethonium therapy, farmers' lung and idiopathic fibrosis. Busulfan therapy and pulmonary fibrosis have been reported by several other authors.[5-21] These eighteen reports of 22 total cases have established busulfan lung as a clinical entity.

It is interesting to note that busulfan and hexamethonium (an antihypertensive agent) are straight chain compounds which are symmetrically methylated. Interstitial pulmonary fibrosis was first attributed to hexamethonium in 1953 by Morrow, Schroeder and Perry.[22] Their observations have been confirmed by others.[23-26] Symptoms of tachycardia and dyspnea usually begin after one month to one year of hexamethonium therapy. The radiologic and histologic picture is very similar to busulfan lung and suggests a common pathogenesis.



Figure 5. A section of Epon embedded tissue cut at 0.5 micron reveals marked hyperplasia of the alveolar lining with many cells assuming columnar or cuboidal configuration (toluidine blue stain).

Marinho and Martins in 1956,[27] Kyle et al, in 1961,[5] Leake et al. in 1963[6] and Harold in 1966,[8] described a total of seven patients treated with busulfan for long periods of time who developed signs and symptoms suggesting adrenal insufficiency. In each of these patients, a diagnosis of adrenal insufficiency could not be established. Hyperpigmentation of the skin, similar to that seen in Addison's disease, may be the first sign of this syndrome. The pigmentation is most pronounced on the trunk, face and hands. It may recede when the busulfan is stopped only to recur when therapy is resumed. It has been suggested that busulfan removes an inhibitor of tyrosinase (the enzyme which oxidizes tyrosine to melanin) thus accelerating formation of melanin from tyrosine.[28]

Conclusion

Busulfan may induce cytologic abnormalities in many organs, including the lung. These lesions may represent early malignant change.[29-32] In 1965, Koss et al. reported five patients who developed epithelial changes consisting of cytoplasmic and nuclear enlargement, nuclear hyperchromasia and occasional epithelial giant cells following long term busulfan therapy.[32] These changes were reported in the uterine cervix, lung and urinary tract, organs easily studied by cytology. Discontinuing the drug did not reverse the cytologic abnormalities, which the authors thought represented drug induced malignancy.

In 1968 Min and Gyorkey reported a case of bronchiolar cell carcinoma associated with diffuse interstitial pulmonary fibrosis in a patient who had been treated for five years with busulfan for chronic granulocytic leukemia.[9] Bizarre atypical epithelial cells were present. On gross examination, a tumor which had infiltrated the lymphatics and metastasized to one of the regional lymph nodes was found. The authors suggested that the carcinoma may have been induced by the busulfan.

We postulate that our patient developed busulfan lung and an adrenal insufficiency-like syndrome as the result of busulfan therapy for chronic granulocytic leukemia. Adenocarcinoma of the prostate was found and treated three years after busulfan treatment was begun. Since carcinoma of the prostate is a common disease in elderly men, we can not suggest a causal relationship with his therapy in spite of the documented oncogenicity of alkylating agents in general. ◄

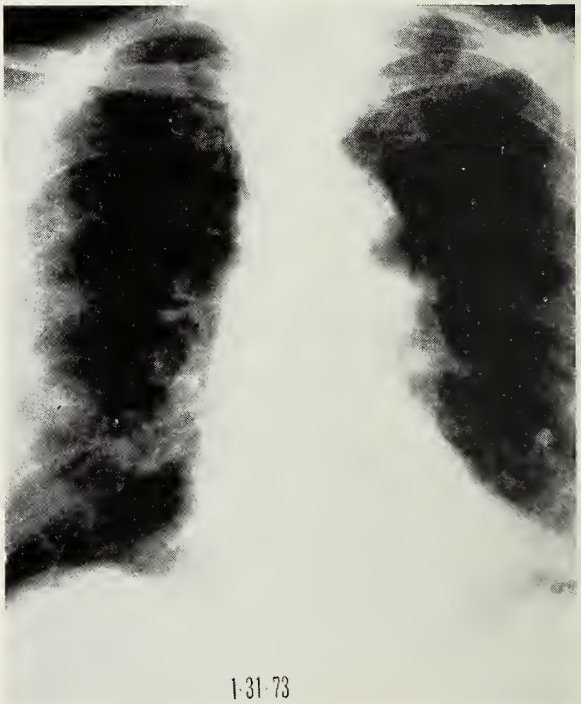


Figure 6. A followup X-ray (4½ months after Fig. 2) reveals partial clearing of both lung fields.

References

A complete bibliography for Busulfan Toxicity may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe St., Suite 3510, Chicago 60603.

the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

A 74-year-old female who had noted an increasing mass in her abdomen for the st 15 years. An IVP and arteriographic study are shown. A retrograde was tempted and could not be completed.



Figure 1

What's your diagnosis?

1. Carcinoma of the Kidney
2. Xanthogranulomatous Pyelonephritis
3. Tuberculosis of the Kidney
4. Non-functioning Hydronephrosis



Figure 2

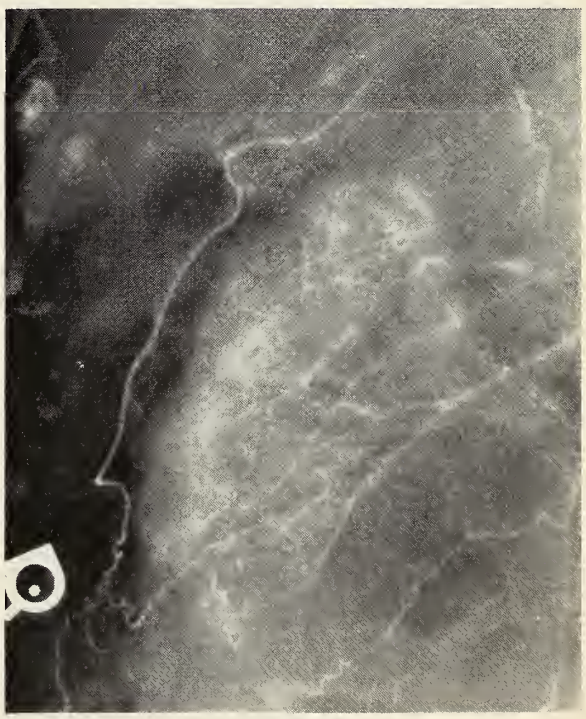


Figure 3

(Answers on page 380)

Guest Editorials

A Retrospective View of Nursing and Medical Practice

Prior to World War II there were very limited numbers of private duty or staff nursing positions for professional Registered Nurses. Most hospitals were staffed primarily with student nurses. Relatively few of the available graduate registered nurses were regularly employed, usually from one special or private duty case to another. It was even difficult for them to have and plan a day off. Frequently they wondered why their respected seniors and peers were not dong as well as they, usually being among the unemployed. Sometimes they explored in conversations with each other the misfortunes of these "more competent" peers. It always was a puzzle, with the solution never reached.

As for those fortunate nurses who were employed most of the time, they did what came naturally. Physical care was executed with decorum. However, they didn't stop here.

They did not expect the patient to conduct himself according to their standards. Neither was an attempt made to "make him over." They talked things over, and did not try to reason, reward or punish. Their conduct created a very low-pressure social environment. These nurses neither sanctioned nor approved his behavior. They respected him as an individual human being who possessed worth and dignity.

The patient often expressed specific feelings of various complex reactions to both physical and psychological manifestations, either negative or positive; appropriate expressions were allowed. Nurses knew how to stop talking and listen. The patient was understood and considered to have worth.

When the patient had problems, he was permitted to proceed according to his natural design, without deprivation or forcing. This was done in a milieu created by the nurse and by a process which also supplied a social direction to his achievement. It was personally satisfying to him and allowed for achievement of fullest possible potential.

When the patient presented symptoms, they looked for causes. Now these are called manifestations of 'unmet needs.' When these needs were met, the symptoms subsided or vanished.

Behavior of the patient was always closely observed and changes noted. These nurses didn't stop there; they silently questioned what the behavior accomplished, what the patient was trying to express; what was underneath the patient's behavior and what meaning this behavior had for the staff. Thereupon they would respond realistically to his verbal or non-verbal communication. Whether the patient was the day laborer or the president of the bank, all received preferential treatment. Color, creed, culture or religion were just facts of life.

There was an awareness that how nurses functioned as well as their physical presence affected the patient. A realization existed that one can't talk a patient out of a belief, even if there was no basis in reality.

These professionals were careful to communicate clearly and in a nonthreatening manner, on a level the patient could understand. Double messages by word or deed were anathema. Patient behavior was channeled from restricted areas to those of freedom. Patient needs were met. Reasonable and practical restrictions were enforced in an understanding and supportive manner, even when the patient found them difficult to understand.

These regularly employed nurses performed with insight, thoughtfulness, and understanding based on knowledge, empathy, tact, and consideration. They had integrated into their patient care that which is now "labeled" the general principles of psychiatric nursing.

These principles are again expounded as a critical need for the other major health professional, the physician. Recently, The American Medical Association in a new publication labelled *Prism, The Socioeconomic Magazine,* had a lead paper by Dr. Robert J. Haggerty of the

University of Rochester. His thesis was that the major task for the medical education system of the future will be to identify and educate bio-social physicians. It was significant that he stated a need for two general attributes: warmth and leadership ability.

The quality of warmth has been shown to be the most important attribute of the successful therapist dealing with patients with psychological or physical problems. (Are they not inseparable?)

Both nursing and medicine are acutely aware that technical and scientific advances have overcome abilities to keep pace, or even adapt. However, we are rediscovering that the art of nursing and medicine, our attitudes, as well as knowledge and judgement, are still and always will be basic. We "treat" people who have all the fears, problems, strengths, hopes and now articulated demands identical to our own.

Abraham Gelperin, M.D.
Manteno State Hospital

On Reducing Perinatal Mortality

The Chicago Board of Health recently initiated a program for in-hospital peer review of perinatal deaths. This should have a significant effect on the lowering of perinatal mortality in the City of Chicago. Another program directed toward the same objective, and presently only in the discussion stage, is the utilization of certified nurse obstetricians (midwives) in the Board of Health prenatal clinics. Each of these programs has merit, and, in my opinion, warrants the support of all involved in the direct and indirect delivery of obstetric and pediatric newborn care.

Recent regulations of the Chicago Board of Health require all Chicago hospitals caring for mothers and their newborn to establish perinatal death review committees. These will be comprised of members from divisions of obstetrics, pediatrics, anesthesiology, pathology, and nursing services, or others directly concerned with perinatal deaths. All such deaths, inclusive of stillbirths above 1,000 grams and livebirths that die within the first 28 days of life, will be studied from the viewpoints of cause of death, responsibility, and preventability. The findings of the committees shall be sent to the Board of Health for its analysis, interpretation, and direction.

Thus, a nomenclature of underlying factors and causes of perinatal deaths, and their responsibility and preventability, will evolve. This will enable the concerned hospital medical and administrative staffs, as well as the staff of the Board of Health, to delineate the medical, social, economic, or public health areas wherein corrective or preventive measures are necessary. A significant bonus from this city-wide self-analysis of perinatal mortality will be the exact placement of responsibility for such mortality, which I suspect will demonstrate that its solution will require help not only from physicians, but also from the community, religious and lay leaders, and from the parents themselves.

Concerning the assumed controversial use of certified nurse obstetricians in Board of Health prenatal clinics and selected back-up hospitals for those clinics, it should be pointed out that this program is a pilot, in Chicago, only for selected Board of Health prenatal subjects. A similar midwifery activity for prenatal subjects under the responsibility of the New York City Health Department has been very effective in providing improved pregnancy and interconceptional care to those subjects. If this midwifery activity in Chicago is found to be successful, it could be expanded according to need. Only nurses with Master's Degrees in midwifery would be utilized to provide care to the normal prenatal subject. She would deliver only certain subjects in selected hospitals The complete activities of the midwife would be under the direction of certified obstetricians in the clinics and hospitals.

The above programs have the support of the Maternal and Child Health Advisory Committee to the Chicago Board of Health and of the consultative obstetric and pediatric staffs of the Board.

The Board is to be complimented for these innovative efforts to effect a lowered perinatal death rate in the City of Chicago.

Robert E. Lane, M.D.

FIGHTING INFLATION/RECESSION

"We don't want any single group of the population to bear a disproportionate share of the cost of fighting inflation. But, on the other hand, we are not doing any favors for people by tolerating inflation either. Fighting inflation and recession simultaneously is a difficult job. But we have the knowledge to do it. All we need now is the leadership."—Arch Booth, president of the Chamber of Commerce of the United States.

Some Psychological Aspects of Industrial Injury

By Jack C. Berger, M.D./Chicago

It is common knowledge that emotional and psychiatric factors can and often do play significant roles in the causation of industrial accidents. This is so well known that the term "accident prone," once restricted to medical and psychiatric writing, is now a part of every day usage. The extent to which emotional and psychiatric factors influence the outcome of industrial accidents is not as widely recognized. At times, emotional trauma may be the sole result of such accidents and this phenomenon constitutes the subject matter of this paper.

Historical Data

During and after World War I, the term *"Shell Shock"* came into use. It was applied rather indiscriminately to men whose symptoms ranged from mild confusion, disorientation and memory loss to complete incoherent mutism. Although physical injury was often present, it was not necessary to make the diagnosis. Soldiers without any injury could be the victims of the severest forms of *"Shell Shock."*

Knowledge in psychiatry increased greatly in the following years. By the time of the Second World War servicemen who experienced milder forms of emotional disturbances were classified as *"Combat Fatigue"* or *"Battle Fatigue."* Those with more severe symptoms were labeled *"War Neurosis"* or *"War Psychosis."* Here again it was not necessary that any actual physical injury be present; nor was it even necessary that the servicemen be exposed to enemy action, although most cases occurred under such conditions. In either event, the etiology was the same, namely an individual and his ego structure reacting to the exposure or possibility of exposure to injury or death. This was the background for the concept of traumatic neurosis.

Industry has continued to expand and grow in all directions, including the growth of machines in size, weight, power and rapidity of action which enables them to destroy a hand, arm or entire person in an instant. The concept of traumatic neurosis was slightly different from that of war neurosis in that it did not occur in anticipation of being exposed to injury or death, but following an actual accident or injury.

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The symptoms of traumatic neurosis varied. Mostly they were of an anxiety nature, with the patient tense, and nervous, or sometimes with loss of appetite and sleep disturbances. In addition, there was often excessive concern over the injury on the part of the injured worker, and fear of further injury if he returned to work too soon. In other patients the symptomatology was more of a depressive nature with the patient feeling that he might never be able to return to work, that his career had been cut short and that he was a failure as a father and bread winner. In fact, almost any symptoms characteristic of the various neuroses have from time to time been diagnosed as traumatic neurosis simply because they occurred following an accident.

Current Concepts

Today the symptoms of mental or psychiatric disturbance which appear following an injury are classified under one or more existing diagnostic categories on the basis of which symptoms predominate. Following this line of thinking, the term traumatic neurosis was dropped from psychiatric nomenclature and does not appear in the *Diagnostic and Statistical Manual of Mental Disorders* second edition, 1968. This manual lists seven standard neuroses: 1) Anxiety; 2)Hysterical (with two subtypes: conversion and dissociative); 3) Obsessive compulsive; 4) Depressive; 5) Neurasthenic; 6) Depersonalization and 7) Hypochondriacal. Following are cases giving some examples of these:

Case 1

A.G., a 39-year-old gas company worker, was injured in an explosion in which he was blown some twenty or thirty feet out of an excavation. Fifty percent of his body was burned, but he sustained no fractures or internal injuries. Following nine months of multiple grafting procedures, he was released from the hospital. In spite of good healing, A.G. remained unable to work, experienced frequent episodes of anxiety, tension,

(Continued on page 384)

Supradiaphragmatic Cyst of the Thoracic Duct

By Balbino B. Fernandez, M.D., Noel S. Browdy, M.D., Noble Correll, M.D./Chicago

A case of a cyst of the supradiaphragmatic portion of the thoracic duct is presented and the literature on the subject has been reviewed. This represents the **sixth reported case** *of such a cyst in English literature. The findings of the chemical and electrophoretic analysis of the fluid contained in the cyst are discussed.*

Although cysts of the cisterna chyli are not uncommon, those arising from the thoracic duct are extremely rare. In two recent series of mediastinal cysts and tumors totaling 138 cases, only one case of thoracic duct cyst was reported.[1,2] To date, only five cases in living patients have been reported in English literature. The purpose of this report is to present another such case and describe the chemical findings found in the fluid from the cyst.

Emerson described the case of a 20-year-old woman who entered the hospital for study of a mediastinal tumor that had been found on a routine X-ray film.[3] It is of interest to note that the cyst had an inferior pedicle and was filled with milky fluid. During surgery it continued to refill with clear fluid which welled up from a duct found to be below the diaphragm.

Bakst reported the case of a 42-year-old man with a cyst located in the posterior mediastinum, just above the diaphragm.[4] There was a pedicle at its inferior aspect which appeared to extend below the diaphragm. The cyst was filled with milky fluid which was seen to well up through a small opening at the inferior aspect of the cyst. Cholesterol content of the cystic fluid was 80 mg/100 ml.

A third case was described by Barlow and Gracey.[5] The patient was a 76-year-old woman who had a rounded swelling in the root of the left side of the neck, deep to the sternomastoid muscle. A biopsy was performed and the swelling was found to be a cyst filled with clear fluid. A second operation was performed and a cystically dilated segment of the thoracic duct was removed. It contained clear fluid. The cyst had a distal, probe patent afferent duct and an obstructed efferent duct that joined the subclavian artery.

Thomas, et al., reported a case of a 43-year-old asymptomatic man.[6] In a routine chest X-ray film a mediastinal mass was demonstrated. It was at the level of the aortic arch; angiograms showed no communication between the mass and the aorta. At surgery a cyst filled with milky fluid was found; it had an inferior pedicle that arose from the thoracic duct.

In a report of forty-two cases of congenital cysts of the mediastinum, Ochsner described one cyst of the thoracic duct that was located toward the right side of the superior posterior mediastinum.[2] There was no description of the characteristics of the cyst.

Case Report

A 41-year-old, white, automobile salesman was hospitalized for investigation of a left apical chest mass discovered on X-ray when the patient complained of an unrelenting cough with right sided flank pain. This proved to be a self-limited viral respiratory infection.

In 1966 an automobile accident had resulted in fracture dislocation of the right femur and multiple fractures of his right ribs with associated traumatic pleurisy and pneumonitis. Two follow-up chest X-rays were normal.

Physical examination revealed this 234 lb. white male was not in acute distress. Lungs were resonant to percussion, and auscultation and ventilatory excursion was adequate. No chest bruits were noted. Cardiovascular examination revealed the peripheral pulses to be intact bilaterally with a blood pressure in the upper ex-

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tremities of 140/90. No abnormal neck vein distension was noted. The heart tones were distant but not inappropriately soft for the patient's chest dimensions, and thus were felt to be normal. Third and fourth sounds were absent. No hemodynamically significant murmurs were noted. There was no evidence of clubbing, cyanosis or abnormal venous pattern over the thorax, abdomen or trunk. Abdominal examination revealed no evidence of pain, tenderness or masses. Genital and rectal examination were within normal limits.

The patient underwent diagnostic evaluation, which included a chest X-ray demonstrating a mass in the posterior apical mediastinum, and tomography, which outlined a smoothly marginated mass thought to lie within the posterior mediastinal space (Fig. 1). An arch angiogram failed to demonstrate any vascularity in the tumor and revealed an extrinsic pressure defect of the vasculature adjacent to the tumor. A bronchoscopy and bronchogram were performed. The results were unremarkable, again showing in the left apical area an extrinsic pressure defect on the bronchogram markings. Sputums revealed normal bacterial flora without evidence for fungi or tuberculosis. Cytology was negative. Laboratory testing was essentially within normal limits aside from a mild elevation in the cholesterol and uric acid. Complete blood count, urinalysis, serology and multi-channel auto-analyzer testings were otherwise within normal limits.

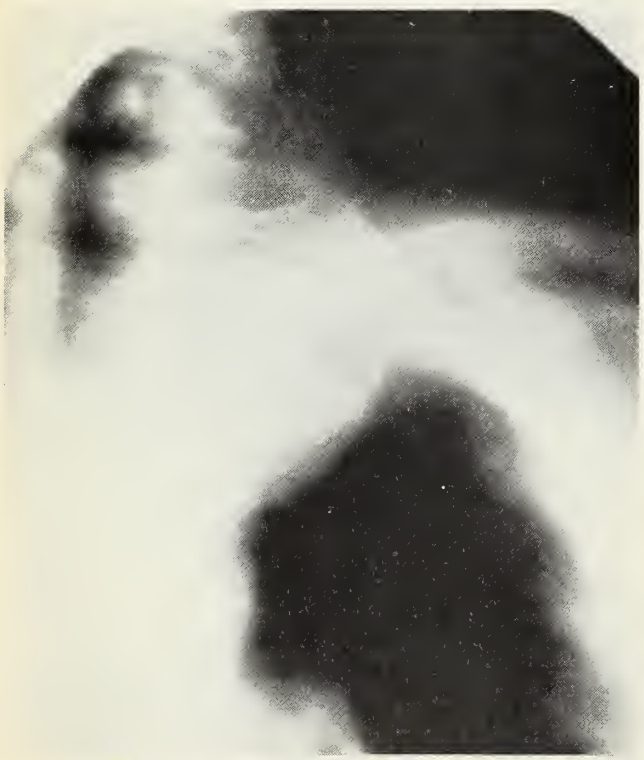


Figure 1. Chest X-ray film showing a round mass in the posterior apical mediastinum.



Figure 2. Inner surface of the wall of the cyst showing translucent and thickened areas.

A thoracotomy was performed under general endotracheal anesthesia. The thorax was entered through the fourth left intercostal space. The lungs were found to be normal by inspection and palpation. There was a soft fluctuant mass in the superior posterior mediastinum, approximately the size of an orange, its blood supply appearing to arise from the intercostal vessels as well as from the thoracic inlet. The tumor was removed intact. The postoperatory course was uneventful.

Pathological Findings

Gross The submitted specimen consisted of a smooth, fluctuant, pale pink yellow cystic mass measuring 4.0 x 5.5 x 3.5 cm. (Fig. 2). No

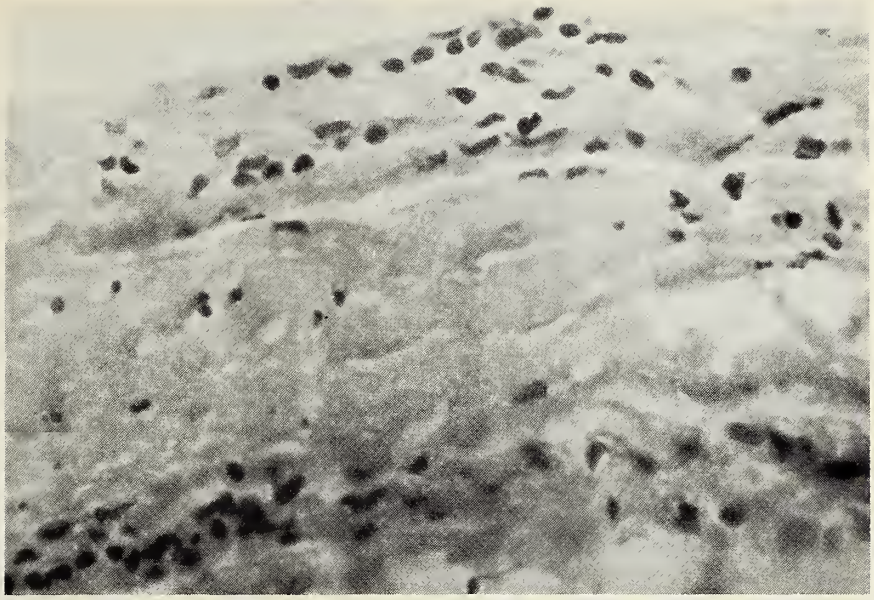


Figure 3. Section of the cystic wall showing absence of lined and scanty mononuclear cell infiltrate.

evidence of pedicle was found, the external surface being covered by a thin layer of fibroconnective tissue. The cavity contained about 45 cc. of milky fluid and tiny fatty droplets were observed on the surface. The wall measured an average of 1 mm. in thickness. The inner lining was wrinkled, generally glistening with multiple patchy areas of white and yellow discoloration. **Microscopic** The wall was made up of dense fibroconnective tissue. In some areas an attenuated single layer of cells suggested there was a lining. However, definite evidence of epithelium was not found. Toward the periphery occasional smooth muscle fibers were observed. Scattered throughout the wall there were small collections of lymphocytes and histiocytes, the latter with abundant, pale eosinophilic, foamy cytoplasm (Fig. 3). In the areas of patchy, white-yellow discoloration the wall was thicker and showed rather acellular partially hyalinized fibrous tissue.

Microscopic examination of the fluid revealed the presence of a few erythrocytes and lymphocytes. Chemical examination showed a triglyceride value of 770 mg/100 ml and a cholesterol of 371 mg/100 ml. Lipoprotein electrophoresis was performed and showed a broad dark band in the areas of the chilomicrons and a light diffuse one at the beta lipoprotein region (Fig. 4).

Discussion

Different from other cysts of the mediastinum, where the origin can be established on embryological basis, the origin of thoracic duct cysts is a subject of debate.[7] Ross, in a review of the surgery of the thoracic duct, recognized two varieties of cysts: lymphangiomatous (congenital) and degenerative (senile).[8] Lymphangiomata of the thoracic duct may produce single or multiple chyle containing channels, forming a tumor-like mass in the mediastinum. Such cysts are apt to rupture into the pleura and are a rare cause of chylothorax, as reported by Maurer and Correll.[9,10] Our case appears to correspond to the degenerative variety with extensive fibrosis of the wall and focal infiltrates of mononuclear cells resembling the changes observed in atherosclerosis.

It is of interest that the cyst appeared to be blind. The chemical analysis of the fluid obtained from the lumen showed marked increased values for cholesterol and triglycerides (371 mg/100 ml and 770 mg/100 ml respectively) as compared with the values of normal lymph obtained from human thoracic ducts by Werner (80-186 mg/100 ml for cholesterol and 60-380 mg/100 ml for triglycerides).[11] It is possible that obstruction of the communicating channels produced a blind cyst with concentration of the chyle and elevation of the values of cholesterol and triglycerides. The pattern of lipoprotein electrophoresis reflects the elevated values of these two fractions with a thick dark band in the chilomicron area and a lighter definite band in the betalipoprotein region. It has been stated that the essential elements in the formation of these cysts is obstruction associated with degeneration of the wall.[7,9]

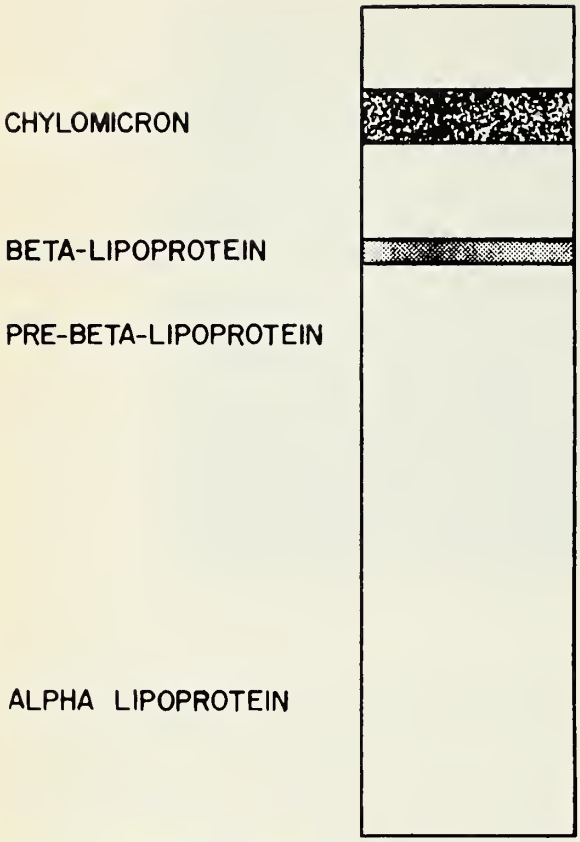


Figure 4. Schematic drawing of the pattern of lipoprotein electrophoresis. Note thick dark band in the chilomicron area. A thin, lighter band is present in the beta lipoprotein region.

In previously reported cases, the cyst was usually found on routine X-ray of the chest, the only exception being the case of Barlow and Gracey, in which the mass was present at the root of the neck.[5] In none of these cases was the diagnosis established prior to surgery. Lymphangiography could be helpful in establishing a specific preoperative diagnosis in such cysts. ◄

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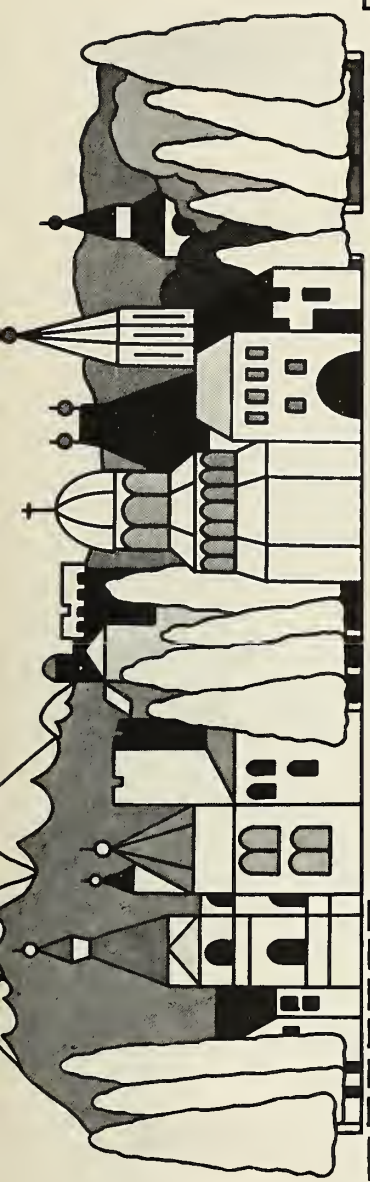
Good Samaritan

Assume that while driving along the Baltimore Beltway you notice a person lying alongside the roadway in obvious need of immediate medical attention. Although morally and professionally you want to stop and assist the injured stranger, must you legally? And if you do, what possible legal implications may arise and what legal protections will be available to you—the good samaritan physician?

Generally, the common law imposes no positive legal obligation on a physician to medically assist an accident victim, unless the physician causes the accident and thus is responsible for the injured stranger's condition. However, in the absence of this special relationship and the resulting duty, when a physician voluntarily aids an injured person, he acquires a potential liability. Generally, the physician is relieved of liability as long as he acts with reasonable care and does not worsen the injured stranger's condition. Although this test in equivocal, the disparity appears to be between misfeasance and nonfeasance.

Applying the common law to our hypothetical case, a physician is under no positive legal duty to medically assist the injured victim, regardless of the nature and extent of the injuries. However, once the physician commences emergency aid, he must act with reasonable care and not further imperil the injured stranger. (Robert A. Rombro: *Maryland State Med. Jl.* [May] 1974, pg. 48)





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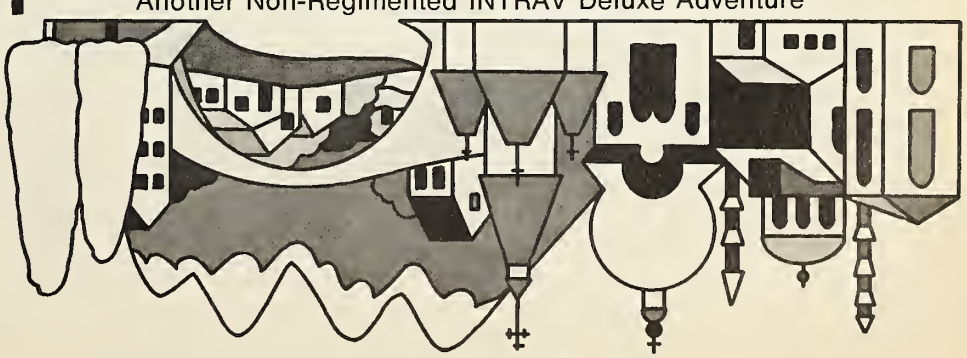
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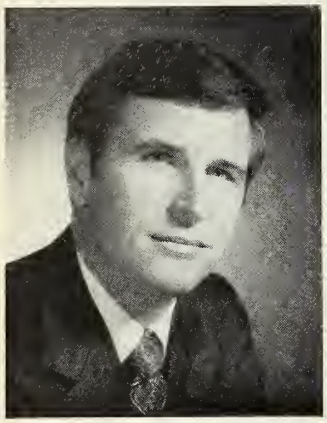
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President's Page

RETURN TO BASICS

1975 elections . . . another slate of officers . . . another round of enthusiasm . . . high hopes . . . and a new medical society year begins. Perhaps this is not the year to follow the pattern of renewed hopes and promises. Rather, this may be the year to build on what has gone before and on the efforts of those who have worked in the immediate past toward resolving our internal conflicts. If we do not gain from this recent experience and profit by the actions which have been forthcoming, then we are truly missing an opportunity to grow.

One thing has become evident in recent months and is reflected in my feeling that we must return to a stronger position of leadership in directing our destiny as a profession. I feel this can be done if we will cease to apologize for the imperfections of our organizations and cease to be so seemingly apologetic for our beliefs and philosophies. We must return to the basic philosophy of "being a physician" and by recognizing the basic philosophy and function of a medical organization.

The basic philosophies of the physician and his concern for the patient are time-honored, time-tested and irrefutable. It is the forceful intrusion into these areas of social welfare, legal and legislative concepts which have produced consternation throughout our profession. Indeed, some among us appear to have lost sight of our basic beliefs and have begun to compromise without questioning the *medical* expertise of those who demand change.

As we return to these basic concepts of patient care which experience has taught us are right and proper, we need not allow those who would impose their programs for materialistic reasons only to force change upon us without consideration of our experience and knowledge. We must insist that those who would impose these programs first *prove* that their programs will improve upon the present doctor-patient relationships, as well as justify these programs on some basis other than political rhetoric. Further, as I said before, we must stop compromising for the sake of convenience and expediency even before our arguments have been heard.

To assure growth during this year, I ask you to increase introspection into your own beliefs and transmit these beliefs increasingly to those who have assumed the burden of leadership and guidance. Increased effectiveness can come from restatement of our basic philosophy and reestablishment of the basic pride that we must have in the medical profession and in the art of being a physician. With continued adherence to these principles we can meet any challenge that may come from the social, political or socio-economic areas, evaluate them in the proper responsive manner and, most importantly, incorporate these new concepts in our practice when they are *truly beneficial* to our patients and their well being.

J. M. Ingalls, M.D.

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Doctor's News

INVITE MEDICAL PROFESSION TO REFER ALCOHOLISM PATIENTS TO MODEL CITIES FREE PROGRAM—The Model Cities-Chicago Committee on Urban Opportunity free Alcoholism Program invites the medical profession to refer their family related, low income alcoholic patients to Alcoholism Counselors in eleven Urban Progress Centers throughout the city. There they will receive free counseling, supportive services, and referrals for medical treatment.

This program is designed to integrate the entire family into the Model Cities-CCUO comprehensive service system so all may benefit from their resources. The clients are also eligible for 175 adult education courses which Model Cities has initiated in 11 Urban Progress Centers. Community hospitals are utilized for medical treatment-detoxification and other community resources are used to provide shelter.

Fred T. Davis, consultant to the program, says, "This program is demonstrating its ability to provide significant services to poverty alcoholics and their families." This program is supported by the National Institute of Alcohol Abuse and Alcoholism of the U.S. Department of Health, Education, and Welfare. Admission to the Alcoholism program is via the Alcoholism Counselor at the nearest Urban Progress Center. For further information call: 744-7555.

TWO NEW PUBLICATIONS OF THE ILLINOIS COUNCIL ON CONTINUING MEDICAL EDUCATION HAVE JUST COME FROM THE PRINTER: *Case Discussion & Problem-Solving* offers a detailed procedure on how to use case-discussion for in-hospital CME and includes also four sample cases that have been tested for effectiveness. Authors are ICCME's Executive Director, Leonard S. Stein, Ph.D., and Richard L. Byyny, M.D., Assistant Professor of Medicine, The Pritzker School of Medicine, The University of Chicago.

Planning CME to Fit Staff Interests: Patient-Problem Inventory describes a procedure used at Methodist Hospital, Peoria, to (a) evoke and (b) identify attending staff CME interests. A key feature is a pair of especially-designed worksheets to enable individual physicians to inventory the patient problems they confront and decide which represent "learning needs." Authors are: ICCME's Executive Director; N. K. Furlong, M.D., Medical Director of Methodist Hospital; Dean Bordeaux, M.D., and Fred Z. White, M.D., Co-Directors of the Peoria School of Medicine Family Practice Residency at Methodist Hospital.

Both are free, upon request, to *Illinois* CME planners—hospital DME's, hospital and specialty society program chairman, et al. To those from outside Illinois, a charge must be made to cover costs of printing, postage, and handling: *Case-Discussion*, $2/copy; *Patient-Problem Inventory*, $1/copy; payment must accompany each order. To obtain a copy of either, write to: Illinois Council on Continuing Medical Education, 55 East Monroe St., Suite 3510, Chicago, IL 60603.

AMA NINTH NATIONAL SOCIOECONOMIC CONGRESS will be held April 25-26, in Atlanta, Georgia. The subject of the Congress will be National Health Insurance. A panel of health care experts will discuss NHI's impact on health care delivery and executives in industry and medicine will focus on the mechanics of an NHI program. Physicians attending the Congress will receive nine hours of Category I credit toward the AMA's Physician Recognition Award. For further information contact the Div. of Medical Practice, AMA, 535 N. Dearborn St., Chicago, 60610.

PHYSICIANS IN THE NEWS—**LeRoy P. Levitt, M.D.**, Director of the Illinois Department of Mental Health and Developmental Disabilities, has been elected to the eight-man board of directors of the National Association of State Mental Health Program Directors.

Richard H. Kessler, M.D., associate dean and professor of medicine, Northwestern University Medical School, has been elected a fellow of the Hastings Center Institute of Society, Ethics and the Life Sciences. The Institute is an interdisciplinary and international research and education center. Dr. Kessler, who has become nationally known for his concern with improvement in health care delivery, is responsible for two new programs in the curriculum at NU, Medical Care Organization and Medical Ethics, as well as other long-range planning activities at NU.

Four department chairmen have been appointed at the Chicago Medical School. **Lawrence L. Hirsch, M.D.**, who was instrumental in establishing the family planning program and the family practice residency at the Illinois Masonic Medical Center, is the new chairman of the department of primary health care. **Joseph W. Linhart, M.D.**, a noted cardiologist and director of the division of cardiology at Hahnemann Medical College in Philadelphia, will assume the chairmanship of the department of medicine. The third appointed chairman is **William Schumer, M.D.**, department of surgery, who presently serves as professor of surgery at West Side Veterans Administration Hospital in Chicago. **Donald F. Pochyly, M.D., M.Ed.**, has been named chairman of the department of health sciences education at the University of Health Science/The Chicago Medical School.

Other doctors in the news are: **Joseph B. Kirsner, M.D.**, new chairman of the National Scientific Advisory Committee of the National Foundation for Ileitis and Colitis; **Gabriel H. Schwartz, M.D.**, and **Ben Carasso, M.D.**, recently elected to the American College of Physicians; **Rolando de la Torre, M.D.**, 1975 medical staff president for Forest Psychiatric Hospital, Des Plaines; **Howard W. Schneider, M.D.**, new president of the Chicago Committee on Trauma of the American College of Surgeons; and the newly elected officers of the Chicago Foundation for Medical Care, **Andrew J. Brislen, M.D.**, re-elected President-chairman; **Maynard I. Shapiro, M.D.**, re-elected vice-president; **Richard L. Jensen, D.O.**, secretary, and **Joseph H. Skom, M.D.**, re-elected treasurer.

Northwestern University has been awarded a two-year grant of $59,437 by the National Multiple Sclerosis Society to continue support of research by **Dr. Howard L. Lipton**, assistant professor of neurology at the Medical School.

Upon the recommendation of the Illinois State Medical Society, the Illinois Department of Public Health has appointed **John W. Bowden, M.D.**, Joliet, to serve a four-year term on the Long Term Care Facilities Advisory Council.

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THE HARTFORD

Medicine in 2001

(Continued from page 342)

occurrence of venereal disease and genital cancer.

Again, I emphasize that twenty-five years from now, we will still be concerned with food, energy, heat, water, air, and space because of the increase in our population. The doctor will have to work with economists and social planners to achieve better care for the individual. The politician will also have to be involved, in the examinations, communications, continued education, manpower adjustment, and self care patterns that will be devised. Regardless of this interference, I trust there will be no evaporation of the doctor-patient relationship. I believe that health care will be managed as a large trust by Government regulations at all levels. Inflation will raise the cost of medical care perhaps as high as $500.00 a day.

There will be more generalists than specialists. Total national health expenditures which cost 12 million dollars in 1950, cost 100 million dollars today, and certainly will be greatly increased by 2001 A.D. There will be a Federal Health Insurance. Also, there will be an invasion of the confidentiality of doctors' records. Record keepers documentations, computerization of all reports will increase, rather than lessen.

More doctors will go out to remote areas but this will remain a troublesome problem. Graduating medical students will spend at least one year in a community of 5000 people or less. This would relieve the maldistribution of medical care as well as stimulate the compassion human quality in most young doctors. *Science and Medicine* is a fickle, evanescent charmer, lacking resistance to the *Arts and Medicine*. The doctor will be a physician as well as a problem solver, a manager, a skilled technician, a teacher, an advisor, and an advocate.

Winston Churchill said, "In the past we had a light which flickered in the present we have a light which flames, and in the future there will be a light that shines all over the land and sea." I believe the light of medical progress will shine as it never has before, no matter where one lives, or how. We will receive more skilled, more effective, more compassionate medical care by 2001 A.D.

(This essay is derived in part from the Horace E. Turner Memorial Lecture given at the Hall of Fame before the International College of Surgeons on Tuesday, May 21, 1974.)

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ardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy.
Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin, since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake. *"Destabilization" of Previously Controlled Diabetic:* When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal; unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
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EKG of the Month

(Continued from page 353)

Answers: 1. D, E 2. A, B, C, D, E (all)

The ECG in Figure 2 shows marked ST segment elevation in leads I, avL, V_1 to V_5 with premature ventricular beats. This case is an example of Prinzmetal's variant angina. Although the quality and location of the chest pain are typical of angina, it usually occurs at rest without any precipitating factor. ST segment evaluation is seen during the chest pain. Ventricular arrhythmias and atrioventricular block have been reported and may require treatment. The ST segment elevation or current of injury occurs over the electrocardiographic area where the myocardial infarction may develop. It is regarded as severe angina or unstable angina. Most authors would recommend coronary arteriography for a full evaluation. The syndrome has been reported in patients with severe proximal, fixed, single vessel obstructions. It also has been seen in multiple coronary vessel disease and with coronary artery spasm in an otherwise normal coronary arteriogram. This patient had a diffusely diseased right coronary artery and 80-90% obstructions in the proximal left anterior descending and proximal obtuse marginal coronary arteries. Propranolol and nitroglycerine as well as other measures for severe angina pectoris are indicated. The value of saphenous vein coronary artery bypass surgery is still not clear. It is not indicated where coronary spasm occurs in an otherwise normal coronary arteriogram. For more discussion see the December, 1974, issue of *Chest*.

Viewbox

(Continued from page 361)

DIAGNOSIS: *Xanthogranulomatous Pyelonephritis*—This is a specific pathologic entity characterized by unilateral severe pyelonephritis. Pathologically renal tissue is replaced by a fibrosis and granulomatous yellowish tissue which contain lipid. The roentgen findings of this condition are:

1. Non-function of the kidney,
2. Calculi limited to the involved kidney, obstructive in half of the cases,
3. Pyelocalyceal changes suggestive of chronic pyelonephritis of long standing; may be diffuse or segmentally localized.
4. Varying degrees of obstructive changes (not all are obstructive).
5. Multiple irregular filling defects in the pelvis and the calyces suggestive of tumor; nonopaque calculi or blood clots (the tumefactive types).

The arteriogram reveals changes suggestive of inflammatory disease and marked displacement of the capsular artery away from the kidney cortex. There were severe inflammatory changes in the specimen and replacement by fat throughout the substance of the kidney and in Gerota's capsule (accounting for the position of the capsular artery on the arteriogram).

British Health Service

An entire generation of young Britishers thus learned to take for granted that the State looked after their health. And, in contrast to the doctors who so bitterly opposed the service at its inception, a whole generation of physicians, dentists, and nurses has also been conditioned to accept that the State, through them, provides.

Both these assumptions have now been shattered—by inflation. When the Health Service began, its founders believed that universal care would reduce illness and the demand for treatment. In fact, the demand for state-provided benefits has proved limitless. The founders of the Health Service estimated its cost in 1974 would be $400 million; in fact, it is nearly 20 times that.

The Government simply does not have the resources to be a universal provider, and one way in which it has economized has been to hold back spending on salaries and wages. In consequence, as inflation bites deeper, staff morale has sunk to its lowest ebb. Special "non-essential" services, such as cosmetic dentistry, operations for "minor" complaints like varicose veins, or provisions of oxygen for housebound asthmatics, have had to be curtailed.

Even essential services have at times had to be trimmed. Some emergency wards have been closed; some cancer patients have gone potentially fatal days without radiotherapy, because of staff shortages. (*American Medical News* [October 21] 1974.)

The post-T & A patient:

another type for TYLENOL® acetaminophen products



When the post-T & A patient requires an analgesic, a new problem arises. Hemorrhagic tendencies following the use of aspirin after tonsillectomies have been reported.[1,2] In a patient who "...has recently undergone a surgical procedure or has another underlying hemostatic defect, aspirin ingestion may cause significant bleeding....Aspirin is absolutely contraindicated in such situations. Acetaminophen...could replace aspirin in these instances."[3]

The post-T & A patient is only one of several 'types for TYLENOL' antipyretic-analgesic products—that is, patients who should avoid aspirin. Considering *all* of them, wouldn't it provide added safety (as well as added convenience) to recommend TYLENOL products routinely for simple analgesia?

References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

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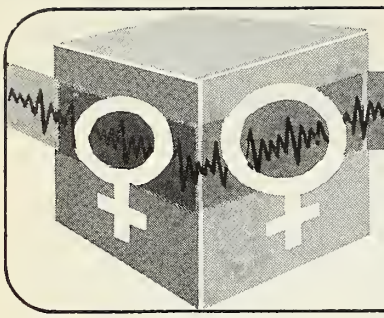
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pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

Women in Medicine

Prior to the year 1850 only two women physicians' names are found in medical history: Dr. Margaret Logsden of Shawneetown and Dr. Charlotte Stringer who practiced in Aurora about 1848. The State of Illinois has been slow in providing medical education for its women.

There were attitudes, beliefs and prejudices which constituted the average male doctor's view of the female sex during the nineteenth century. Women were usually considered to be mentally, as well as physically inferior to men. Few persons believed it possible for a woman to engage successfully in a business or profession. Popular opinion characterized women as being uncertain, lacking rational judgment, fickle in purpose and indecisive in action, qualities which would totally unfit them for professional pursuits. Then, too, Victorian concepts of modesty and morality complicated the possibility of men and women together listening to physiological discussion and dissection of the human body.

In 1852 Emily Blackwell was denied permission to complete her studies at Rush when the Illinois State Medical Society censured the school for admitting a woman. In 1869 women were accepted by the Chicago Medical College but at the close of that year the male students asked to have them dropped, charging that certain clinical materials and observations had been omitted because of the women's presence.

Prominent physicians of Chicago were among the most vociferous opponents of medical education for women. Eventually they approved of separate colleges for female instruction, but they still fought the admission of women into the American Medical Association. In 1876 a Chicago medical woman, Sarah Hackett Stevenson, courageously took the first seat ever occupied by a woman in the history of the American Medical Association. Dr. Stevenson was a native of Illinois and a graduate of the Woman's Hospital Medical College.

Woman's Hospital was established in 1865 by Mary Thompson as a hospital for indigent women and children. While managing that hospital, Miss Thompson applied to both Chicago medical schools for permission to complete her medical education but was refused until 1869. That year she was selected as one of four women to be admitted to Chicago Medical College in a one-year experiment, and finally received her degree. However the other three female candidates were left stranded when the college decided not to admit more women!

This defeat was a blessing in disguise. Dormant plans for a school exclusively dedicated to medical education of women now sprang to life. In 1870 the Woman's Medical College had its first course of lectures. To secure a faculty must have been a Herculean task at a time when it was a disgrace to be seen walking on the street with a woman doctor to say nothing of the enormity of showing her a kindness!

Thus were the beginnings of women in medicine in Illinois in the not too distant past. The Bicentennial Committee will present from time to time, short biographies of Illinois medical women.

Hella Holman, Sangamon County Auxiliary member has submitted the following: Margaret Taylor Shutt was born in Springfield, January 13, 1868. Through her father William Shutt, a state senator and lawyer, she became interested in law and was admitted to the bar at Mt. Vernon in 1894. However, while studying law she became interested in forensic medicine. After completing her law degree, she began medical studies at the University of Pennsylvania and Cornell University. Dr. Shutt passed the State Boards of New York with highest honors and joined the medical staff at Bellevue Hospital. In 1908 she returned to her native Springfield to practice medicine. Three years later while affiliated with St. John's Hospital as a pathologist, she contracted typhoid fever and died a short time later on January 24, 1913. A young, promising life and career had ended too soon.

Niranda Sargent, daughter of Winthrop and Louise Smith Sargent, was Decatur's first woman doctor. She was born in Claremont, N.H. on

October 28, 1832 and died in Decatur, Sept. 30, 1885. She was known particularly for her temperance activities.

Dr. Sargent was a school teacher for several years at a salary of $600 annually. She became greatly interested in the people in the southeastern part of Decatur where there was the most poverty. She gave of her strength and energies in constructive service with house to house medical relief and personal instruction. Eventually she gathered a group of children into a Sunday School which met in the home of Sam Friend, a basket maker.

"Sargent Chapel," on South Broadway, was built in 1886, a year after her death. It was the predecessor of the Cleveland Avenue Methodist Church.

Macon County had two women doctors in its membership in the year 1899. Today there are four women doctors in Macon County Medical Society.

Dr. Maggie Yelton Downs was a pioneer woman doctor of Vermilion County. She was born in 1868 in Newton, Illinois. Her parents were Charles and Susan Margaret Shryok Yelton. She graduated from Keokuk Medical College, University of Iowa in 1893. She was married to Dr. Henry R. Downs. They came to Danville in 1901. They shared offices until his death in 1940. She died in 1952 at the age of 84.

Vermilion County

One of the most noteworthy early settlers of this community was Lura Guymon, born in Ohio in 1794. She spent the better part of her life in the vicinity of Catlin, just southwest of Danville, having come there with her husband about 1830. They built a small cabin at Butler's Point which served as a residence for the couple and a place of shelter for the faithful mule on which she had ridden from their old home in Ohio. Her husband had walked all the way alongside her.

She was locally known as "Grandma Guymon." There were several hundred Indians in the area at that time who soon learned to know and respect her as their doctor and mid-wife. She had studied medicine in Ohio, and while there were no licensed physicians in that area, she probably knew as much as the male doctors who started coming in the county shortly after she and her husband arrived.

Her knowledge of medicine and herbs and their uses appealed to the Indians and they made her their friend. No day or night was ever too bad or stormy for the white medicine woman to answer the call for help. She would ride horseback over the trackless prairies or through forests to bring a new baby into this world. It is said she officiated at approximately 1,000 such events.

"Grandma" Guymon died in 1884 at the age of ninety years.

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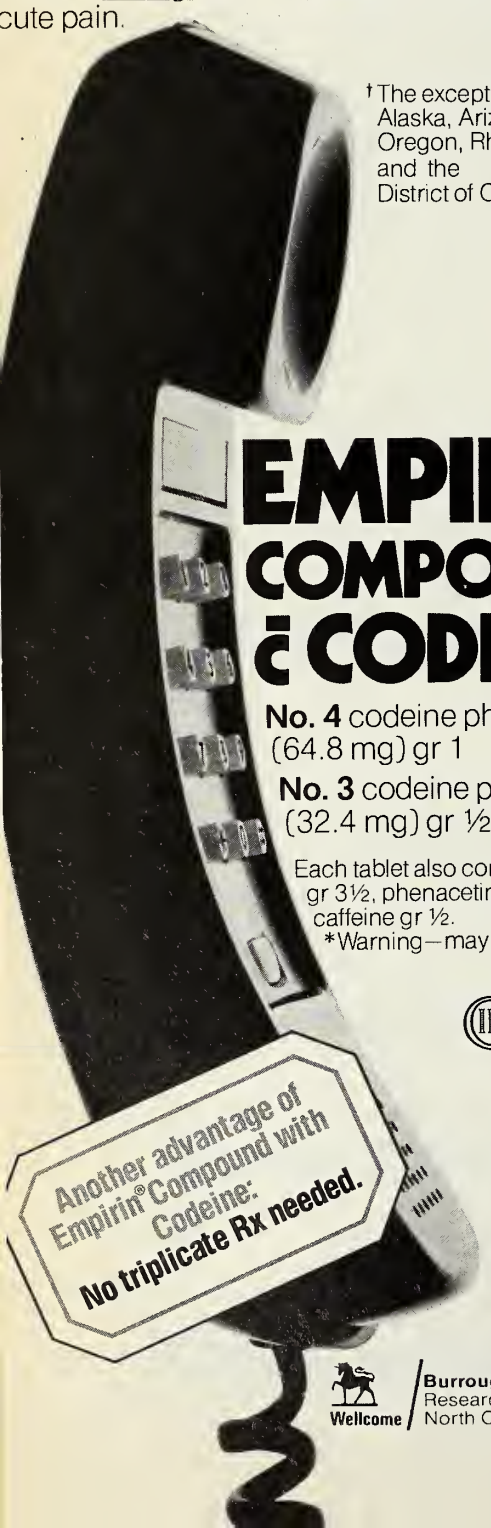
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Psychological Aspects of Industrial Injury

(Continued from page 364)

shaking and excessive perspiration. Even though his hospital bills had been paid, he'd received a reasonable settlement, and was offered a different job away from any possibility of explosion, he would not return to work. Diagnosis: *Anxiety Neurosis.*

Case 2

G.L., a 25-year-old female, was injured when the safety guard on the cutting machine she was operating failed, with resultant amputation of the left hand at the wrist. Following primary surgical repair and healing of the wound, the patient refused any additional care. She would not consider any kind of prosthesis, cosmetic or functional. She remained at home, withdrawn, would not see friends and avoided her family. G.L. also refused to see claim agents and offered to sign a release without any claim if they would leave her alone. Diagnosis: *Depressive Neurosis.*

Case 3

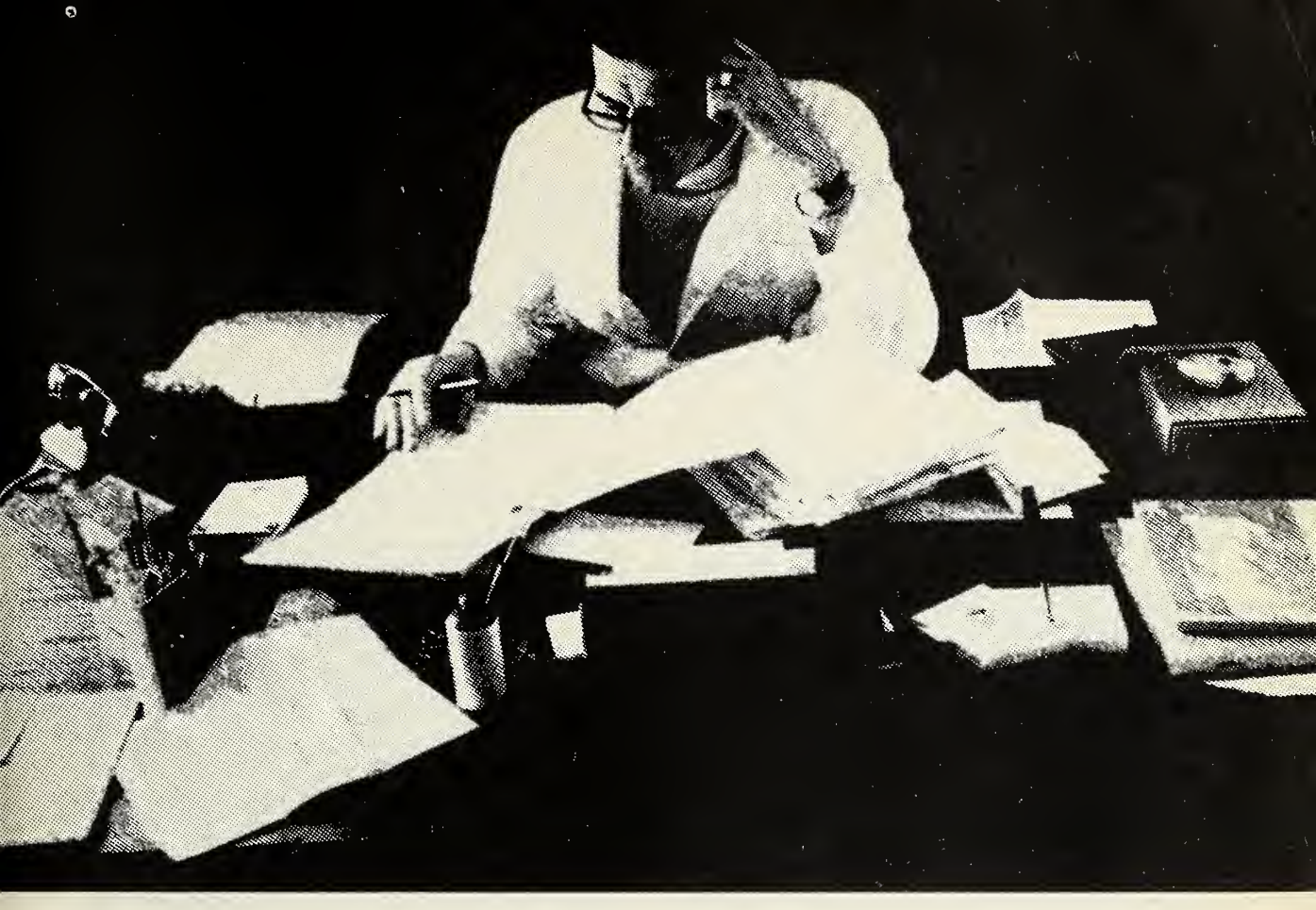
J.R., a 54-year-old masonry worker, was standing on a scaffold on the outside of a building twenty-five stories above street level, when the scaffolding gave way. He was held by his safety belt, dangling for some five hours before rescue attempts were successful. He sustained no serious physical injuries but was given two weeks off work. When J.R. returned to work he found himself totally incapable of working at any level above that of the first floor. If the scaffold was raised beyond that level, he would be overcome with panic and have to be taken off. Diagnosis: *Phobic Neurosis.*

Summary

The outcome of industrial accidents and the worker's reaction to his injury may be powerfully influenced by the factor of compensation. The examples given were carefully selected to show cases where compensation was not a major factor in the injured worker's response to his injury. ◄

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The Doctor's Wife: Meeting Her Own Needs*

By Rosanne Krcek Frank, R.N., M.S.Ed./Sycamore

Today's culture is one in which the female still attains much of her whole identification through the status of her husband. Forced into this alien identificatory process, she is deprived of evolving a true identity of her own, resulting in what Erickson refers to as identity diffusion. This creates conflictual stress, with resultant social and sexual mal-adjustments.

The physician is conditioned to respond and react to illness with supportive activity. His personal and professional existence are generally expected to be readily identifiable as one and the same. His wife and family may unconsciously learn to utilize the one certain route to getting a modicum of that attention which he is observed giving to his patients—the plea of some physical distress.

Given these conditions it is no wonder, as reported in *Medical Economics* April, 1973, that one-fifth of all doctors and their wives sought psychiatric or other counseling help. I would hazard a guess that too often it was the wife who did so, simply from a logistical standpoint that she had the time!

Some years ago, when I started to write about my experiences as the wife of a physician in a semi-rural area, I reviewed the literature to see whether there was sufficient evidence to make some generalizations about doctors' wives and their coping experiences. I had to conclude that my problems were unique to me. All other professional wives must obviously have been most content with their existence. Certainly, none of them exposed any cracks in the foundations of their life-style. One lone article, written anonymously in 1958, was primarily devoted to the concept of sublimating one's own needs even more vigorously in order to make things "as smooth as possible for the doctor," and being "repaid at the end of all the years of loneliness, waiting, and inconveniences when some grateful patient tells you what a wonderful person you married!" It occurred to me to wonder what happens if that never occurs; what if it is all taken so for granted that one never gets a feed-back? If I was distressed enough to seek help, this obviously "belonged to me" to quote our 'now' generation.

Novelists always have been fascinated with the charisma attached to the physician, the healer. Chekhov wrote very understandingly about them. There is a physician in every one of his plays, and in many of his short stories, but I do not remember any of them having had wives. By and large, in the literature, if the doctor did have a wife she was a nebulous blob of protoplasm identified only as HIS wife.

At this point someone will be saying "ah, ha" she has fallen into the chauvinist trap—talking about the medical profession in typically masculine terms. What about the spouse of the female doctor? Within the limits of this paper it is not *apropos* to delve into any problems which may exist in that relationship. I do not believe that it is at all similar simply because any male who has had an ego strong enough to woo and win a woman aggressive enough to breach the walls of admissions committees and make it into medical school, is apt to have an education equal to hers, and as a result an identity which allows him freedom to allow her psychological territoriality within the marriage framework.

To identify the population which gives evidence of being in most distress, it is the "rank and file" wife—that woman who married her doctor before she herself had attained the se-

Presented at the 20th Annual Meeting of the Academy of Psychosomatic Medicine. November, 1973, Williamsburg, Virginia.



ROSANNE KRCEK FRANK, R.N. M.S.Ed, Sycomore, is Assistont Professor of Cammunity Health and Comparative Health at Northern Illinois University School of Nursing. She is the wife of Irving Frank, M.D.; together they hove presented ond authored numerous articles on psychosomotic medicine ond changing roles of members of the health professian.

Mrs. Frank, a graduate of Cook County School of Nursing, is a member of the American Medicol Writers Association, and is a former Editor of "Pulse" for the Womon's Auxiliary to the Illinois Stote Medicol Society.

curity of economic or professional equality. This would also hold true, perhaps, for the female who comes from a lower social stratum than does her physician husband.

This year it is almost impossible to browse through any of the medical literature that comes so generously into your offices as largesse from the medical supply companies, without seeing an article about the emotional stresses of the physician, his wife, and/or his children. What has caused this spate of articles recently? It does not take too much perspicacity to understand the factors which have contributed to a climate which is fertile for all kinds of mischief! The resurgence of the Women's Rights movement, the general unrest of our younger population, an affluent society which has raised the educational expectations of women, and the existential approaches to basic questions of life are all important facets of a changing milieu.

There is need in a discussion of this type to extrapolate what belongs specifically to the physician-spouse arena rather than belonging generally to middle-class, mobile, executive class marriages. Many social scientists have recently leveled their research at the destructive milieu often causing dysfunction in the relationships between the upper echelon executive and his family. While the end results may look similar—depression, alcoholism, marital discord, and psychosomatic illness, I believe, that etiologically speaking, there is a difference. One of the prime factors is the ambivalence on the part of the public toward the doctor, which is often translated to resentment when his wife and children make any demands upon HIS time. Time which they feel they have first call upon! Ever try to tell a patient that you cannot meet their demands because you promised to do something with your wife and children?

One can identify certain developmental stages which are crucial in the marital relationship. These developmental periods can, briefly, be subdivided into three phases, each having its own Ericksonian crises.

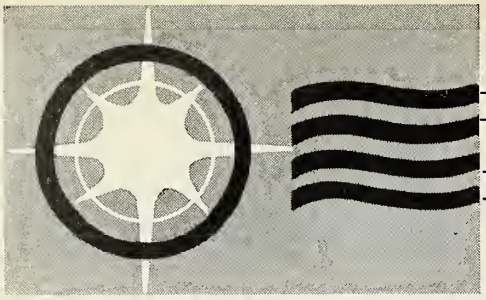
Introductory phase: the first ten years, encompassing medical school, residency, and the first years of practice. Marriage may have begun at any of these times. This phase is characterized by the singleness of purpose on the part of the male. He is almost totally involved in activities outside the family. The professional demands made upon him, in terms of time and energy, in this period of his life are all-consuming, and far surpass those usually made upon the average academician, executive, etc. at a comparable level of development.

As to the wife, she has entered a new role, and is often heard to cry that she feels like the "loneliest woman in town." She may be attempting to cope with unrealistic expectations of her in her role as the doctor's wife. There is a struggle between inner and outer expectations, which are frequently dissonant. The environment in which husband-physician is practicing will determine the degree of this conflict. For example, in a small town there is a greater spectrum of involvement across socio-economic lines, and inter-personal relationships become more intense and complicated. From the transactional point of view, she is faced with the need for making extremely sensitive responses on many levels in her daily contacts.

Phase 2: I like to think of as having the potential for being the questing years, the growing years. It is the time for the raising of the children, and for giving emotional support to the family because father is apt to be a busy professional. However, once the children are in school, she is in a position to initiate activities aimed at *personal* growth. Generally speaking she is in a stable situation, as contrasted with the mobility imposed upon the wife of the rising academician or executive. This provides a root system which can be supportive, in an emotional sense, and conducive to giving her a strong sense of identity within the community. It is during this period that she can take advantage of opportunities to enhance her creative potential. This may take the form of education, business involvement, organizational or political involvement, and is constructive preparation for the next developmental period.

Phase 3: The self-gratification period. This is the period when full time involvement becomes more feasible. The "empty nest" gives time for self-fulfillment. Phase two activities now culminate in self-identity crystallization. In my case it was academic achievement. It is a period in which there is great potential for receiving ego rewarding recognition. Organizational presidents are usually women of this age group!

Each developmental phase has its crises. One attempts to resolve these in a mature adult fashion, facing the reality of each situation. Utilizing one's inherent capabilities for growth during each of these periods can result in a serenity which allows for a mature, co-pathic relationship within a marriage. By utilizing the positive aspects of being married to a successful professional, with all that implies—the status, the economic security—one can achieve a high level of satisfaction. This means that one has to take advantage of the opportunity for *personal* growth and become a co-equal partner in the marital relationship. ◄



membership forum

March 19, 1975

Dear Dr. Van Dellen:

In your March editorial you refer to Mr. Fields and Mr. Zipperstein as pharmacists. I must point out that neither of these men were pharmacists. It is unfortunate that the Chicago Tribune chose to refer to them as "druggists," thus giving the impression that they were pharmacists, since the terms are synonymous in many people's minds. Mr. Zipperstein's son, Eugene, who is a pharmacist, sought membership in this Association in 1974. His application was denied.

Your are absolutely correct that the fraud is massive. Some of it is on the part of pharmacists and doctors, but more of it is probably perpetrated by factoring firms. Much evidence has been laid before the authorities, and eventually the worst offenders will walk the plank. Our concern is the same as yours. Besides the question of fiscal irresponsibility, we must ask what kind of health care services are these people getting. We would appreciate a united effort by all segments of the health care field to demand action on this matter. We don't like our fellow pharmacists or drug store owners to get away with fraudulent practices any more than you are proud of your fellow physicians implicated doing likewise.

Yours in service,

Donald V. Vaught, R.Ph.
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Comparison of Newborn Infants in Raised and Horizontal Cribs

By Harvey Kravitz, M.D./Skokie

Sixty-seven normal full term infants weighing over 2500 grams who were free of perinatal disease were placed in cribs with the head of the crib raised 20° and compared with a like number of infants who were observed in cribs in the horizontal position. No significant difference in the number of episodes of cyanosis, choking or gagging, regurgitation, vomiting, or apnea were noted in the two groups.

Pediatricians have been divided on the question of whether an infant should be placed in a crib with the head raised or in a crib in the horizontal position. I believe that raising the infant's mouth above the level of the stomach could result in less vomiting, regurgitation, gagging and choking, with reduced chances of aspiration of milk into the infant's lungs. Infant seats are commonly used in the hospital as well as the home to treat infants with regurgitation and vomiting.

A second argument for elevating the head of the crib is that the weight of the liver and the rest of the abdominal contents would be displaced away from the diaphragm. Thus, there would be a decrease in the work of breathing and a more rapid expansion of the newborn's lungs.

This study reports the clinical effects of raising the head of the crib of 67 newborn infants of normal weight and gestation compared to a like number observed with the crib in a horizontal position.

Methods

The subjects were 134 full-term infants weighing over 2500 grams, free of perinatal distress, with Apgar scores at one and five minutes of 8-10. These infants were observed in the regular nursery at Lutheran General Hospital, Park Ridge. Sixty-seven infants were observed in cribs placed in a horizontal position and served as the control group. A similar number of infants were observed in cribs with the head raised 20 degrees. This was accomplished by placing plastic blocks under one end of the metal support of the crib mattress. A survey of our nursery prior to the study showed that approximately half of the physicians routinely ordered the head of the bed elevated and half ordered that their infants be kept in the horizontal position. The infants were observed for the following signs: (1) cyanosis, (2) choking and gagging, (3) regurgitation, (4) vomiting, (5) apnea. Each episode was recorded by the attending nursing staff. Infants were observed from birth to four days of age in both groups. All infants in both groups were placed in the prone position during the period of the study.



HARVEY KRAVITZ, M.D. is a practicing pediatrician fram the Deportment of Pediatrics, Lutheran General Hospital, Park Ridge, Illinois. He is a member of the National Accident Prevention Committee of the American Acodemy of Pediatrics, and a member of the Child Health Committee of the Nationol Safety Council.

TABLE 1

The effect of position on the number of infants with and without abnormal signs.

Position	No abnormal signs	Abnormal signs	X^2
raised	37	30	N.S.
flat	34	33	N.S.

Discussion

The position in which to place a newborn infant is a problem for pediatricians caring for sick and well infants, in the newborn period and in later infancy. In 1958, Kravitz and associates[1] reported on supine and prone position effects on the respiratory rates of premature and mature newborn infants free of perinatal disease. They showed that premature infants in the prone position breathed at a significantly slower rate than those in the supine position. Respiratory rates of full-term, normal weight infants were the same. In that study mention is made of 4 premature infants observed in the supine position with a 30 degree elevation of the head of

the crib compared to the horizontal supine position. No difference was noted in their respiratory rates.

A recent report by Brackbill and associates[2] on the psychophysiologic effects in the neonate of prone versus supine placement showed that infants in the prone position sleep more, cry less, and move less. No investigation of the effects of elevating the head of the crib was made in their study.

Our data show there was a slight increase in the number of infants who developed clinical signs when placed in the horizontal position compared to those in the raised group. (Table 1) X^2 analysis was non-significant. Those physicians who believe in elevating the head of the crib will be disappointed to know that there were slightly more signs in the infants with their heads raised 20° than those in the horizontal group.

TABLE 2

The effect of position on the number of infants with abnormal signs each seen once.

Position	No. infants with abnormal signs	Cyanosis	Choking or Gagging	Regurgitation	Vomiting	Apnea	X^2
raised	30	2	15	25	4	0	N.S.
flat	33	2	15	27	3	0	N.S.

TABLE 3

The effect of position on the total number of episodes of abnormal signs occuring in infants.

Position	No. infants with abnormal signs	Cyanosis	Choking or Gagging	Regurgitation	Vomiting	Apnea	X^2
raised	30	3	21	50	5	0	N.S.
flat	33	2	24	49	5	0	N.S.

(Tables 2, 3) Differences were not statistically significant.

It is concluded that infants who are of normal birth weight and gestation with Apgar scores between 8-10 and free of perinatal disease have not benefitted by raising the head of the crib 20 degrees. Similar controlled studies of the physiologic and clinical effects of position on infants of low birth weight with and without respiratory disease and infants over 2500 grams with respiratory disease are still needed. ◄

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2. Brackbill, Y., Douthill, T. C., and West, H. "Psychophysiologic effects in the neonate of prone versus supine placement." *Jour. Ped.* 82:82, 1973.

PHYSICIANS WANTED

Specialist and Generalists working together to make the Hartford area a better place to live and practice medicine. Thirteen physicians presently serve the area in two clinics and also solo practice—there is a need for more physicians to serve this fast growing area—specifically in Family Practice and Internal Medicine. A new hospital building has been completed and will provide the best facilities possible. The service area population is over 30,000, while Hartford is a community of 7,000 and part of the metropolitan Milwaukee Planning Area, less than 30 minutes away from major cultural, educational and social resources. Hartford and its outlying communities offer more of a rural community flavor with proximity to lakes, ski hills and other recreational advantages. This invitation to Hartford, Wisconson is the co-operative effort of the physicians, clinics, hospital and interested community leaders. Contact the Hartford Community Physician Research Committee by letter or phone, through N. K. Reynolds, at Hartford Memorial Hospital, 1032 E. Sumner, Hartford, Wisconsin 53027, (414) 673-2300.

PURDUE DEFIBRILLATION CONFERENCE

The Biomedical Engineering Center of Purdue University will hold a conference in Lafayette, Indiana from October 1 to 3, 1975 covering the practical and clinical aspects of cardiac defibrillation. The speakers have been selected based upon their positions as leaders in their respective field. The topics to be discussed include clinical, basic science, and engineering aspects of electrical defibrillation as it pertains to the needs of physicians, nurses, emergency medical personnel, hospital engineers, equipment manufacturers, and research scientists. The state-of-the art of defibrillation techniques will be presented and examined critically and a major goal of this three-day conference will be to integrate all available technology for optimization of ventricular defibrillation. The registration fee of $95 includes proceedings and two luncheons.

For further information, please contact:

Write: Division of Conferences and Continuation Services
Stewart Center, Purdue University
West Lafayette, Indiana 47907

Phone: Area Code (317) 749-2533



The Case for Moonlighting

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

By Michael Hughey, M.D.

Within the state of Illinois and beyond, institutions of post-graduate medical education still exist which forbid the practice of moonlighting. Even within a single institution, one resident may spend his free time as he pleases; another resident in a different specialty may not. The days of indentured servitude passed long ago, yet some hospitals and departments still hold tenaciously to the belief that they "own" their residents' services twenty-four hours a day. Should any resident or group of residents have the temerity to challenge the hospital's right to control their lives beyond normal working hours, as occurred in a well-known teaching hospital several years ago, these residents can expect nothing but forced resignations and dismissals with threats of board-certification blackball.

The benefits of moonlighting for residents are many. For the resident who is in debt and supporting a growing family, the benefits are obvious. Currently, the cost *to the resident* of putting himself through college and medical school can run as high as $50,000. The interest payments alone on loans of that magnitude are staggering. While no one would dispute the fact that residents are much better paid than they were in the past, no resident, even on a generous salary, can maintain his family above poverty level without moonlighting income if he has any significant loan outstanding. To arbitrarily refuse this resident the opportunity to better provide for his family in his own free time is obdurate.

Many community clinics and emergency rooms which take care of indigent patients are staffed solely by moonlighting residents. Because there are not enough practicing physicians to staff these facilities, moonlighting residents have provided an indispensable service in medical care for this segment of the population. For two years a neighborhood clinic in Chicago has remained closed because residents could not be found who were permitted to moonlight, and the clinic could not afford to pay a private physician. The patients who were attended there are still cut off from primary medical care in their own neighborhood.

There are not enough practicing physicians willing to provide many of the services moonlighting residents perform. Besides working in low funded clinics and busy emergency rooms, residents often perform the dull, routine physical examinations required by insurance companies. Residents are also the doctor on the bench at many school athletic events. It would be impossible to find enough private physicians willing to spend their Saturday afternoons in this way.

The moonlighting experience itself is educational. Frequently emergency rooms are the only access a resident has to education in primary care medicine. Some residents staff community hospital delivery rooms at night, gaining experience in the management of labor, and assisting on Caesarean sections. Some residents provide *locum tenens* coverage for physicians on vacation, thereby gaining a first-hand look at private practice. Some residents work in research laboratories, gaining sophisticated knowledge of research techniques, and aiding in the development of scientific discovery.

Numerous arguments have been cited for the prohibition of moonlighting by housestaff, most of them hypocritical. Some individuals feel that moonlighting experiences leave the resident too tired the next day to adequately perform his duties. Yet it is these same individuals who think nothing of the consequences of onerous on-call scheduling of residents within their own training program. No department chairman would fault his resident for being up all night with a crying baby and prohibit him from having any more children. But if a resident is *paid* for staying up all night, he is reprimanded and ordered to stop this activity.

Another argument against moonlighting is that it eliminates valuable reading time. While it is true that reading cannot generally be done while moonlighting, neither can it be done while watching television, or visiting with friends, or playing handball. Yet none of these other activities are prohibited. It seems that it is not the fact that an outside activity occurs but rather that *remuneration* occurs for outside activity which is prohibited. Because an activity results in financial gain is no reason that it should interfere with reading.

Some training institutions believe that their residents should be available twenty-four hours a day, whether they are in the hospital or not. This reason is also cited as a justification for the prohibition of moonlighting. Yet there is no prohibition against the resident taking his children to the zoo, where he may be unavailable for several hours. Again it seems that because remuneration occurs, an activity should be stopped.

Often institutions see no reason to change their policies on moonlighting. They have always had a large number of applicants for a few positions, and believe that they can continue indefinitely on their present course. But I wouldn't be too surprised if the number and quality of applicants begins to drop as time goes on. Medical students are becoming more selective in their search for residency positions, and the option for moonlighting is being questioned by most of them. With the extensive dissemination of information regarding residencies, virtually every medical student will be aware of whether moonlighting is permitted or not. The prohibition of moonlighting will be considered a *disadvantage* of the program.

Prohibiting moonlighting is an archaic remnant of a form of medical education which ended many years ago. The prohibition ignores both the realities of present society and the ideals of personal liberty and freedom of choice. Undoubtedly, this anachronism will be abolished, inasmuch as the vast weight of public opinion among residents demands it. The only question is how soon, and after how much individual harassment and subjugation. ◄

The Injury of the Driver

By George M. Weisz, M.D./Haifa, Israel

In a motor vehicle accident, any type of injury is possible. The pattern of injury can be related to the trauma, to the place occupied by the injured person, outside or inside the automobile, and the position of the driver's torso and extremities at the moment of impact.

Syndromes of organic injuries due to the particular type of trauma were described recently in the surgical literature.[1-3] This article attempts a systematic grouping of injuries sustained by the driver. This might help the physician in the emergency room to find occult injuries in cases where treatment of obvious injuries may distract attention from less severe and less evident ones.

The concept of the "Three level injury" was built from the study of injuries sustained by an unbelted driver and recognized later in many identically injured drivers. Organic injuries were of the head and cervical spine (upper level), of the chest and upper abdomen (middle level), and of the knee and hip areas (lower level).

Case Report

A 27-year-old Negro male was admitted to the Trauma Unit, Cook County Hospital, following a head-on collision. When admitted, he was semiconscious with laceration of forehead and nose. No signs of low perfusion state or respiratory distress were evident. A right knee area escoriation and swelling of the joint area were seen. An infusion was applied, wound care was undertaken, and antitetanus vaccine administered. Patient recovered full consciousness, but remained dizzy, complaining of headache. However, no neurological signs were found. Pain and tenderness over the lower anterior chest and epigastrium were noted. Abdominal tap was negative. EKG was normal. Skull, cervical spine, and chest X-rays were normal. Abdominal plain film X-ray disclosed free retroperitoneal air. Study of the knee area disclosed a fracture of patella. Serum amylase, tested in blood recolted prior to laparotomy, showed an activity of 128 u.Somogyi. At exploratory laparotomy, a tear of the second part of the duodenum, approximately 1 cm., was found and treated with tube-duodenostomy. Recovery was uneventful.

The patient left the hospital after three weeks with a cilindric tutor-cast on the right lower limb. He was followed on the Trauma Clinic, and discharged in satisfactory condition after the cast was removed. The knee joint regained normal range of movement.

Discussion

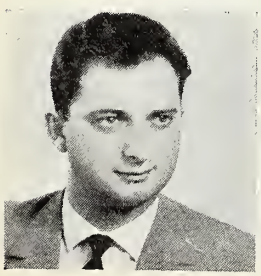
Organic injury to an operator injured in an automotive collision may appear anywhere on the body; intensity by location will be different.

The pattern of the "driver's injury" is developed as follows:

1. *The Upper Level Injury:* Comprises the head and cervical spine. Injury of the forehead and vertex is usually due to a direct blow on the windshield or roof, accompanied by indirect injury of the cervical spine due to extreme extension, flexion or compression. Signs of soft tissue slash, avulsion, or facial damage are clinically evident.

 Findings may be transient concussion of brain, or more serious intracranial damage, with different disturbances in the level of consciousness and various peripheral neurologic signs.

 In the case of cervical spine fracture or disclocation, the peripheral signs will vary from mild paraesthesia through more serious brachial plex stretching, to the critical state of transection with plegia.



GEORGE M. WEISZ, M.D., was born in Rumania and immigrated to Israel in 1959. He received his medical degree from the Hebrew University Medical School in Jerusalem, and came to the United States in 1971 as a special Fellow in Trauma at Cook County Hospital. Currently Dr. Weisz is on staff in the Department of Surgery, Rambam University Hospital, Haifa.

2. *The Middle Level Injury*: Caused by the steering wheel compressing the chest cage and upper abdomen. Signs would be those of sternal fracture, rib fractures, with or without instability of the chest wall. Associated intrathoracic injuries may include hemo- or pneumothorax, contusion of the myocardium or tamponade, aortic wall damage, intrapulmonary hematomas, and tear of the diaphragm.

 A sudden deceleration compressing the organs in the upper abdomen (liver, spleen, pancreas, duodenum and mesenteric root) between the advancing vertebral column and the steering wheel may cause tears of the organs. Also possible would be a rupture of a full bladder.

3. *The Lower Level Injury*: The position of the lower extremities is generally in abduction, external rotation, with flexed knees and flexed hip joints. Trauma may be direct to the knee area and transmitted to the hip and pelvis. Physical and radiological examination may disclose direct injury to the knee area's soft tissue, hemarthrosis of the knee joint, fracture of the tibial plateau and lower third of the femoral shaft. Acetabular fracture with or without central dislocation of the head of the femur may be found in cases where the thigh was in abduction and external rotation at the time of the trauma. In rare cases, where thighs are abducted at the time of accident, hip injury may be a dorsal dislocation of the head of the femur.

The types of injuries described in the above classification are well known to every trauma surgeon. The classification is not only academic but has clinical implications.

An explanation of injury with respect to design of steering assembly recently was published[4].

Care of the injured driver begins at the moment of rescue and transportation. Evaluation of injuries should parallel resuscitation. The latter should follow the rules of the alphabet of resuscitation: *A*irway patency, *B*reathing maintenance, *C*irculatory compensation and *D*rug administration. Definitive conservative or surgical treatment are the final steps[5].

It is believed that the best aid to an injured patient can be accorded by a specially trained team, headed by a Truma Surgeon, mindful of the special nature of trauma pathology.[6] ◄

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2. Markham, D. E.: "Anterior Dislocation of the Hip and Diastasis of the Contralateral Sacroiliac Joint. The 'Rear-Seat' Passenger's Injury," *Brit. J. Surg.*, 59-296-298, 1972.
3. Waddell, J. P. and Drucker, W. R.: "Occult Injuries in Pedestrian Accidents," *J. Trauma*, 11:844-852, 1971.
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6. Freeark, R. J.: "A trauma unit for your hospital," *Hospital Practice*. 3:48-53, 1968.

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

May, 1975

Alcoholism

ALCOHOLISM AND RESOURCES AVAILABLE
For: MDs, Paramedics, etc. Wkly Seminar, May 27, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp., Avon & Schiller, Elmhurst, IL 60126.

Allergy

ENURESIS-DEAFNESS-HIVES-VERTIGO-ASTHMA-ALL DUE TO ALLERGY??
For: MDs, Paramedics, etc. Wkly Seminar, May 20, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir./Med. Ed., Memorial Hosp., Avon & Schiller, Elmhurst, IL 60126.

Anesthesiology

ANESTHESIA FOR DENTISTRY IN THE HANDICAPPED
For: Anesthesiologists, Dentists, Oral Surgeons. Symposium, O'Hare Hilton Hotel, Chgo., May 10—8:30 AM-5:00 PM, May 11—9:00 AM-3:30 PM. **CME Credit:** 10 hrs., AMA Cat. 1. **Fee:** $75: Practitioners; $40: Residents & Interns; $20: Undergraduates. **Sponsor, contact:** IL Soc. of Anesthesiologists, IL Masonic Med. Center, Dept. of Dentistry, 836 Wellington, Chgo. 60657.

Arthritis

IMMUNOLOGIC CONSIDERATIONS IN MEDICAL PRACTICE
For: MDs, Second Wed. of Mo., June 11, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $30. **Sponsor contact:** U of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.
ARTHRITIS IN INDUSTRY
For: Occupational MDs, Nurses, etc., 1½-day Scientific Sessions, May 23: 9:00-5:00; May 24: 9:00-12:00, Continental Plaza Hotel, Chgo. **CME Credit:** AAFP Elective, AMA Cat. 1 (# not yet allocated). **Sponsor, contact:** Central States Soc. of Industrial Med. & Surgery, 150 N. Wacker Dr., Chgo. 60606.

Cardiology

HYPERTENSION
For: All MDs. Symposium, May 13, 8:30 AM, Melrose Pk, IL. **CME Credit:** 1½ hrs., AMA Cat. 2. **Sponsor, contact:** S. Krasnow, MD, Westlake Comm. Hosp. 1225 Superior St., Melrose Park, IL 60160.
ELECTROCARDIOGRAPHY '75
For: MDs, RNs, 1½-day Symposium, May 8-9, Holiday Inn East, Springfield, IL. **CME Credit:** 10 hrs., AAFP Elective. **Fee:** $25. **Sponsor, contact:** Ill. Heart Assoc., 1181 N. Dirksen Parkway, P.O. Box 2666, Springfield, IL 62708. **Co-sponsor:** AHA Council on Clinical Cardiology.

Cardiovascular-Nuclear Medicine

CARDIOVASCULAR-NUCLEAR MEDICINE CME SYMPOSIUM
For: DOs, MDs, RNs, and all interested allied health. 1-Day Lecture-Symposium, May 18, 10:00 AM-6:00 PM, The Deck Motel, Rts. I-80 and IL 82, Geneseo, IL. **CME Credit:** 6 hrs., AMA Cat. 1. **Fee:** $30. **Sponsor, contact:** IL Assn. of Osteopathic Phys. & Surgeons, 5206 S. University Ave., Chgo. 60615. **Co-sponsors:** Iowa Assn. of Osteopathic Phys. & Surgeons, Rock Island County Medical Society & Scott County Medical Society (DO & MD).

Dermatology

For: Dermatologists. 5-Day Course, May 5-9, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Emergency Medicine

FOURTH ANNUAL INDY '500'—POSTGRADUATE COURSE IN EMERGENCY MEDICINE AND EMERGENCY MEDICAL SERVICES
For: Emergency MDs, Nurses, EMTs. Postgraduate Course, May 7-9, 8:30 AM-5:30 PM, Airport Hilton Inn, Indianapolis, Indiana. **CME Credit:** 22 hrs., AMA Cat. 1, ACEP. **Sponsor, contact:** Indiana Chapter, American College of Emergency Physicians, M. J. Graber, MD, 3910 Dundee Dr., Indianapolis, IN 46227. **Co-sponsor:** Emergency Dept. Nurses Assoc.

Family Medicine

27TH ANNUAL POSTGRADUATE SEMINAR
For: Family MDs, Symposium, May 18-22, Arlington Park Hilton, Arlington Heights, IL. **CME Credit:** 16 hrs., AMA Cat. 1, AAFP prescribed. **Fee:** $10 (nonmembers). **Sponsor, contact:** H. Marchmont-Robinson, MD, Ex. Dir./Ill. Acad. of Family Physicians, 14 E. Jackson Blvd., Chgo. 60604.

General Medicine

STATE & NATIONAL BOARD REVIEW COURSE, CLINICAL
For: All MDs. 6-Day Course, May 14-19, Chgo. **CME Credit:** 52 hrs., AMA Cat. 1. **Fee:** $225. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
DIABETIC KETOACIDOSIS
For: MDs & Nurses in IL, Symposium, May 7, 9:00, Chgo. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP Prescribed. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Washington Hosp., 4055 N. Western Ave., Chgo. 60618.
MYASTHENIA GRAVIS
For: MDs & Nurses in IL, Lecture, May 28, 11:00 AM, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, 2 hrs., AAFP. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.
GENERAL MEDICINE LECTURE SERIES
For: House Staff & Gen. Staff, Lecture Series, May 6, 13, 20, 27, Chgo. **CME Credit:** 18 hrs., AAFP Elective. **Sponsor, contact:** A. Sapienza, MD, Dir/Med. Ed., St. Mary of Nazareth Hosp., Cntr., 1120 N. Leavitt St., Chgo. 60622.
MYASTHENIA GRAVIS
For: MDs & Nurses in IL. Lecture, May 28, Chgo. **CME Credit:** 1 hrs., AMA Cat. 1, 2 hrs., AAFP. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Washington Hosp., 4055 North Western Ave., Chgo. 60618.

Internal Medicine

ADVANCED CARDIOLOGY
For: Cardiologists. 5-Day Course, May 19-23, Chgo. **contact:** Cook County Grad. Sch./Med., 707 S. Wood **CME Credit:** 30 hrs., AMA Cat. 1. **Fee:** $175. **Sponsor,** St., Chgo. 60612.
INTERMEDIATE ELECTROCARDIOGRAPHY
For: All MDs. 2-Day Course, May 8-9, Chgo. **CME Credit:** 14 hrs., AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
SPECIALTY REVIEW COURSE IN INTERNAL MEDICINE, CERTIFYING
For: Internists. 6-Day Course, May 12-17, Chgo. **CME Credit:** 60 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Medical/Legal Problems

MEDICAL/LEGAL PROBLEMS
For: MDs. Second Wed. of Mo. May 14, Chgo. **CME Credit:** 3 hrs., AMA Cat. 1, AAFP. **Fee:** $20. **Sponsor, contact:** U. of Chgo., Frontiers of Med., 950 E. 59th St., Box 451, Chgo. 60637.

Musculo-Skeletal Trauma

CLINICAL HOSPITAL PROGRAM ON MUSCULO-SKELETAL TRAUMA
For: MDs, Residents, & Interns. Eve. Clinical Program, May 8, Michael Reese Hosp., 2929 S. Ellis, Chgo. **CME Credit:** 2 hrs., AMA Cat. 1, AAFP. **Sponsor, contact:** Mrs. L. Husa, Exec. Sec., Chgo. Comm. on Trauma of the Am. Coll. of Surgeons. 11255 W. 74th St., LaGrange, IL 60525.

Pediatrics

ADVANCES IN PERINATAL MEDICINE
For: MDs & Nurses, Symposium, May 15-16, 8:00-5:00, Henrici's Clock Tower Inn, Rockford, IL. **CME Credit:** (Applied for). **Fee:** $35. **Sponsor, contact:** G. Staub, MD, Rockford Memorial, Rockford School of Medicine, IDPH, Rockford, IL.
COMMON GENETIC DISEASES
For: Pediatricians. 5-Day Course, May 19-23, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1.**Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.
NO TITLE AVAILABLE—ANNUAL DINNER MEETING
For: Pediatricians. Regular Annual Dinner, May 21, Ambassador West Hotel. Dinner: $12, Social Hr.-6:00 PM. Dinner-7:00 PM. **Sponsor:** Chicago Pediatric Society. **Contact:** L. Zollar, MD, 121 W. 154th St., Harvey, IL 60426.

Radiology

REFRESHER COURSE IN RADIATION SCIENCE FOR THE RADIOLOGIST
For: Radiologists. 7-Day Course, May 19-25, Chgo. **CME Credit:** 59 hrs., AMA Cat. 1. **Fee:** $330. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.

Surgery

ADVANCES IN SURGERY
For: Surgeons. 5-Day Course, May 12-16, Chgo. **CME Credit:** 40 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Cook County Grad. Sch/Med., 707 S. Wood St., Chgo. 60612.
SURGERY
For: Ophthalmologists & Residents. Lecture & Symposium, May 23-24, Drake Hotel, Chgo. **CME Credit:** 12 hrs, AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** Chgo. Ophthalmological Society, 1206 Oakwood Dr., McHenry, IL 60050.
SURGERY
For: Opthalmologists & Residents, Lectures & Symposium, May 23-24, Drake Hotel, Chgo. **CME Credit:** 12 hrs., AMA Cat. 1. **Fee:** $100. **Sponsor, contact:** T. Chalkley, MD, Chmn./Chgo. Ophthalmological Society, 1206 Oakwood Dr., McHenry, IL 60050.
CARDIOVASCULAR SURGERY
For: MDs, Discussion/Lecture/Discussion, May 9: American Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood, 6:00 PM; May 10: Bethesda Hosp., Chgo., 10:00 AM. **CME Credit:** 5 hrs, AMA Cat. 1. **Fee:** $10. **Sponsor, contact:** P. Pierdinock, American Hosp., 850 W. Irving Park Rd., Chgo. 60613.

PATHOLOGY OF DIABETES
For: MDs & Nurses, Lecture, May 7, Chgo. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** F. Lopez-Fernandez, MD, Med. Dir/Martha Wash. Hosp., 4055 N. Western Ave., Chgo. 60618.

Trauma

19TH ANNUAL POSTGRADUATE COURSE ON FRACTURES AND OTHER TRAUMAS
For: Orthopaedic surgeons, Gen. surgeons and MDs. 3½-day Annual Event, May 7-10, Sheraton-Chicago Hotel, 505 N. Michigan Avenue, Chgo. 60611. **CME Credit:** 28½ hrs., AMA Cat. 1, AAFP. **Fee:** $150: Residents, Interns, and Allied Health professions; $45: with letter from Chief of Service. **Sponsor, contact:** R. T. Lidge, MD, c/o American College of Surgeons, 55 E. Erie St., Chgo. 60611.

Thyroid

CURRENT CONCEPTS REGARDING THYROID DISEASE
For: MDs, Paramedics, Nurses, etc., Wkly. Seminar, May 6, 11:30-12:30, Elmhurst, IL. **CME Credit:** 1 hr. AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir/Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

June, 1975

Coronary Rehabilitation—Exercise Testing

EXERCISE TESTING & PRESCRIBING—A PRACTICAL APPROACH
For: Interns, Residents, and Fellows. Symposium, June 12—3:00 PM-9:00 PM; June 13—7:45 AM-5:30 PM; June 14—7:45 AM-10:00 PM; June 15—9:00 AM-11:30 AM, Carson Inn—Nordic Hills, Itasca, IL. **CME Credit:** 21 hrs., AMA, Cat. 1, AAFP Elective. **Fee:** $150: Regular; $75: Interns, Residents, and Fellows. **Sponsor, contact:** Chgo. Heart Assoc., Coronary Care-Rehab. Subcommittee (in cooperation with North Central Regional Heart Committee of the Am. Heart Assoc.), 22 W. Madison St., Chgo. 60602, Attn.: Ms. Bette Naysmith.

Drugs

DRUG INTERACTIONS
For: MDs, Paramedics, Nurses, etc., Wkly. Seminar, June 24, 11:30-12:30, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir/Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

Family Medicine

NORTHERN MICHIGAN SUMMER CONFERENCE
For: (Gen. Interest), 5-day Wkshp-Course, June 23-27, Shanty Creek Lodge, Bellaire, Mich. **CME Credit:** 24 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intraumural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

FAMILY PRACTICE REVIEW-PART I
For: All MDs, 3-Day Wkshp., June 10-12, Stouffer's Inn, Indianapolis, Ind. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** Postgrad. Med. Ed., Ind. U Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

General Medicine

ACIDOSIS AND ALKALOSIS
For: MDs, Discussion/Lecture/Discussion, June 20: Bethesda Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood, IL, 6:00 PM; June 21: Forkosh Memorial Hosp., Chgo. 10:00 AM. **CME Credit:** 5 hrs., AMA Cat. 1. **Fee:** $10. **Sponsor, contact:** Neil Glass, Bethesda Hosp., 2451 W. Howard St., Chgo. 60645.

EVALUATION & MANAGEMENT OF CARDIO-PULMONARY EMERGENCIES
For: GP, FP & Internists. Symposium, June 27-28, Lexington, KY. **CME Credit:** 9 hrs., AAFP. **Fee:** $75. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

HYPERTENSION 1975
For: GP, FP & Internists. Symposium, June 26, Lexington, KY. **CME Credit:** 5½ hrs., AAFP. **Fee:** $20. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Internal Medicine

ADVANCES IN INTERNAL MEDICINE
For: Internists, 4-Day Wkshp.-Course, June 3-6, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 28 hrs., AMA Cat. 1. AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

Obstretics & Gynecology

SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY
For: Ob-Gyn, 10½ day Course, June 2-13, Chgo. **CME Credit:** 86 hrs., AMA Cat. 1. **Fee:** $350. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pediatrics

NEUROMUSCULAR AND LEARNING DISORDERS IN CHILDREN
For: MDs, 5-Day Course, June 9-13, Chgo. **CME Credit:** 27 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pulmonary Disease

PULMONARY DISEASE WORKSHOP
For: Family MDs, 2-Day Wkshp.-Course, June 11-12, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

Surgery

MANAGEMENT OF TUMORS OF HEAD AND NECK
For: Surgeons, 5-Day Course, June 9-13, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

SURGERY REVIEW
For: General Surgeons, General Internists, GP & FP. Symposium, June 1-5, Lexington, KY. **CME Credit:** 25½ hrs., AAFP. **Fee:** $175. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

July, 1975

Dermatology, Pulmonary Function, etc.

REGIONAL POSTGRADUATE CONTINUING MEDICAL EDUCATION PROGRAM
For: GP, FP, IM, Surg. 2/Day Lecture/Seminar, July 26-27, 9:00 AM-5:00 PM, Radisson Hotel, Minneapolis, Minn. **CME Credit:** 6 hrs., AMA Cat. 1, 12 hrs., Basic and Advanced Life Support-Cardiopulmonary Resuscitation, Cat. 1. **Fee:** $60/course—(includes Brkfst. & Lunch; 8 courses offered). **Sponsor, contact:** American Medical Assoc., Dept. of Scientific Assembly, 535 N. Dearborn St., Chicago 60610.

Family Medicine

FAMILY PRACTICE REVIEW—PART II
For: All MDs. 3-Day Wkshp., July 8-10, Stouffer's Inn, Indianapolis, IN. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** J. L. Roscoe, Program Coordinator, Postgrad. Med. Education, Indiana U. Sch./Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

The AMA 1975 Clinical Session

This year's meeting in Hawaii-November 30 to December 5—features 29 CME courses, including "Birth Defects & Clinical Monitoring," "Infectious Diseases in Children," and "Practical Endocrinology"—plus the usual wide array of general sessions on medical topics of current importance. Most courses and sessions meet 7:15 AM to Noon, leaving ample time for relaxation in the beautiful island ambience.

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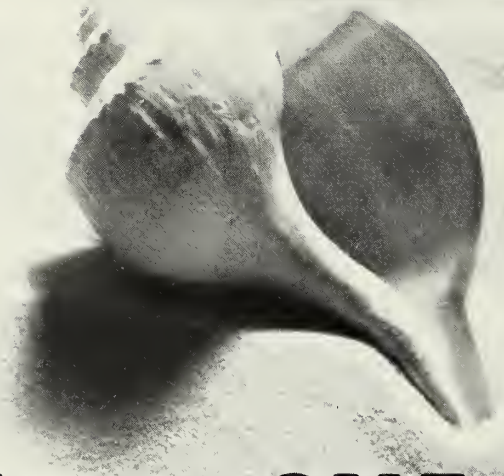
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Also featured are a number of special interest programs: a two-day session on the Medical Aspects of Sports, a series of special courses on clinical pathology, and a joint program by the American Veterinary Medical Association and the AMA on diseases transmitted to man by household pets. Physicians' wives and families will be offered interesting programs co-sponsored by the AMA's Council on Scientific Assembly and the Woman's Auxiliary of the AMA.

For more information, write:
Dept. of Circulation & Records, AMA
535 N. Dearborn St., Chicago, IL 60610

Atlantic City

BLUE SHIELD REPORT FOR Illinois Physicians

Blue Shield Benefits Plan for E. I. Dupont Company Employees

The following summary of the Blue Shield Benefits Program of E. I. DuPont Company, covering its Seneca area and Chicago area employees, is published as a source of information to physicians and their medical assistants when services are furnished to members enrolled in the DuPont program.

In the "boxes" below identifying the respective employee groups, note the special Group Numbers that have been assigned, and the variations in the Type of Benefit for each group covered under separate certificates.

When submitting a claim for a service, please complete a Blue Shield Physician's Service Report form, using the appropriate Group Number and Member Identification Number on the patient's ID card.

SENECA AREA EMPLOYEES:
Group Number: 55017 and 55034
Type of Benefit: 80% Usual and Customary
plus
(1) Out-Patient Diagnostic
(2) Major Medical

CHICAGO AREA EMPLOYEES:
Group Number: 300
Type of Benefit: 100% Usual and Customary
plus
(1) Single OB Benefits
(2) Out-Patient Diagnostic
(3) Major Medical

— SCOPE OF BENEFITS —

The following services will be paid according to the type of benefit held by the member, subject to the terms of the certificate.

SURGICAL BENEFITS . . . are provided for surgical procedures wherever performed, in the hospital, physician's office or at home.

ANESTHESIA . . . by a physician other than the operating surgeon or obstetrician.

MEDICAL CARE IN A HOSPITAL . . . When there is no operation, up to 120 days of benefits are paid for medical treatment by the attending physician for the same or a related condition. Another 120 days of benefits become available for the same condition each time a member has been out of the hospital at least 90 days. For each different illness or accident, 120 days of in-hospital medical care benefits become available immediately.

OBSTETRICAL CARE . . . This Plan will pay to a physician the Usual and Customary fee for delivery of a baby after 270 days of continuous membership. Obstetrical care means the physician's care for the delivery of a baby following a pregnancy of at least 20 weeks or physician's care in a hospital for normal or abnormal conditions related directly to intra-uterine pregnancy. No separate payment will be made for prenatal or postnatal care.

(Continued on following page)

(DuPont's Blue Shield Plan continued)

FRACTURES AND DISLOCATIONS . . . Benefits are provided for the correction of fractures or complete dislocations . . . wherever performed . . . in the hospital, physician's office or at home.

LABORATORY AND PATHOLOGY SERVICES . . . Payment of Usual and Customary physician's fees is made for these services . . . when they are necessary to and in connection with surgical service, obstetrical care or medical care for which Blue Shield is providing benefits.

X-RAYS . . . Benefits are provided if a member receives X-ray treatment from a physician in his office or out-patient department of a hospital for:

(1) The initial correction of a fracture or complete dislocation;

(2) The initial visit for X-ray services rendered in connection with emergency accident care within 72 hours of the accident.

Benefits are also provided for X-rays taken while a hospital bed patient in connection with surgery, obstetrical care or in-hospital medical care, for which the Plan is obligated to furnish other payments.

RADIATION THERAPY . . . X-ray, radium, radon, radioactive isotope treatments for cancer. Members also receive benefits for radioisotope treatments of a thyroid condition, angina pectoris and chronic heart failure.

EMERGENCY MEDICAL CARE . . . Benefits are paid for physician's services for the initial treatment of an acute medical condition within 72 hours of the onset of the condition, wherever the service is rendered.

EMERGENCY ACCIDENT CARE . . . Benefits are paid for physician's services for the initial visit as a result of and within 72 hours of an accident.

SURGICAL SERVICES OF A DENTIST OR PODIATRIST . . . Payment is made for surgical procedures performed by a licensed dentist or podiatrist which may be legally rendered by them and which would be payable if rendered by a physician.

ELECTRIC AND INSULIN SHOCK TREATMENTS AND DIAGNOSTIC SKIN TESTS . . . Benefits will be paid to a physician for these services when rendered to a hospital bed patient.

OUT-PATIENT DIAGNOSTIC SERVICES

"Diagnostic Services" means X-ray, laboratory and pathology services when such services are directed toward the diagnosis of a definite disease or injury provided and billed by a physician. These are in benefit in the out-patient department of a hospital or a physician's office and include electro-cardiogram, electroencephalogram, basal metabolism tests and radio-isotope tests. Payment for these services is limited to a maximum of $100.00 in each 90 days period.

EXCLUSIONS

The basic Plan gives broad protection but does not cover extraction or filling of teeth, surgical preparation of gums or jaws for artificial teeth, or removal of tooth root or infected and diseased gum tissue. Neither does it provide for surgical treatment of corns, callouses, or trimming of toenails.

It also does not cover refractive eye examinations, or glasses, services of a medical assistant, surgical assistant, consultations, or plastic operations unless necessary to correct injuries or congenital deformities.

MAJOR MEDICAL BENEFITS

The Major Medical Expense program is in addition to the basic Blue Cross and Blue Shield program. Blue Cross/Blue Shield will pay a combined maximum of $25,000 per twelve (12) month benefit period and a combined maximum of $50,000 for benefits within a members lifetime.

Payment is made at 80% of the covered medical expenses incurred during any benefit period up to the maximum allowed after the member pays the first $100.00 of the cost. Payment for physician's services will be paid to the doctor unless the member has paid for these services.

FOR EMPLOYEES 65 AND OVER

Blue Shield 65 Supplemental Program to Medicare pays 20% of Usual and Customary fees for:

(1) physician's services in the hospital including up to 120 days medical visits.

(2) minor surgery or accident care in the out-patient department of a hospital.

(3) radiation therapy for cancer when you are a hospital out-patient or receive treatment in a physician's office.

(4) visits to an approved Skilled Nursing Facility, while you are receiving medical benefits there.

IMJ

Illinois Medical Journal

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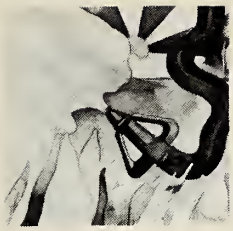
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Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

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Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Clinics for Crippled Children Listed for June

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for June by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-two general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social, and nursing services. There will be five special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

June 3 Carmi, Carmi Township Hospital
June 3 Belleville, St. Elizabeth's Hospital
June 4 Hinsdale, Hinsdale Sanitarium
June 5 Sterling, Sterling Community Hospital
June 5 Flora, Clay County Hospital
June 5 Springfield, St. John's Hospital
June 5 Lake County Cardiac, Victory Memorial Hospital
June 9 Peoria Cardiac, St. Francis Children's Hospital
June 10 E. St. Louis, Christian Welfare Hospital
June 10 Peoria, St. Francis Children's Hospital
June 11 Champaign-Urbana, McKinley Hospital
June 12 West Frankfort, Union Hospital
June 12 Kankakee, St. Mary's Hospital
June 13 Chicago Heights Cardiac, St. James Hospital
June 17 Alton, Alton Memorial Hospital
June 17 Rock Island, Moline Public Hospital
June 18 Jacksonville, Norris Hospital
June 18 Chicago Heights, St. James Hospital
June 19 Rockford, St. Anthony Hospital
June 19 Bloomington, Mennonite Hospital
June 19 Elmhurst, Memorial Hospital of DuPage County
June 23 Peoria Cardiac, St. Francis Children's Hospital
June 24 Peoria, St. Francis Children's Hospital
June 24 Danville, Lake View Hospital
June 25 Springfield Pediatric Neurology, Diocesan Center
June 25 Aurora, St. Joseph Mercy Hospital
June 27 Chicago Heights Cardiac, St. James Hospital
June 27 Evanston, St. Francis Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization, and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children. ◄

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ALDOMET has no direct effect on cardiac function. When ALDOMET is used in effective doses cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is slowed.

April 1-5, 1975 Chicago

Abstracts of Board Actions

Legislative Proposals on Professional Liability

To alleviate the professional liability crisis in Illinois and ensure continued health care for all citizens, the Board of Trustees approved a proposed eight-point legislative program. Sponsors are being sought to introduce bills to:

1. Establish a medical liability review panel—consisting of a judge, physician and attorney — to serve as the entry point for all malpractice claims. The panel would have the power to: (1) dismiss from the suit any defendant it believes has been named without reasonsable basis (2) set a maximum amount of damages to be awarded for valid claims; (3) determine whether the plaintiff has complied with the statute of limitations; (4) determine the reasonableness of attorney's fees; and reduce the award by the amount of any other compensation paid plaintiff.
2. Modify the Statute of Limitations to prohibit the filing of suits more than one year after date of discovery. In no event, shall a suit be filed four years after date of incident.
3. Allow defendants to file counter claims against plaintiffs who file frivolous suits.
4. Safeguard the innocent against adverse publicity by prohibiting disclosure of any defendants named in a malpractice case until the suit is concluded.
5. Eliminate "Ad Damnum", or the seeking of a specific amount of money for damages or a multiple settlement for a single incident.
6. Establish medical disciplinary board to investigate charges of unethical, illegal or incompetent practice filed against MDs, DOs and chiropractors.
7. Provide the Director of Registration and Education with immunity from civil actions in carrying out his disciplinary duties.
8. Amend the Medical Practice Act by establishing additional grounds for revocation or suspension of license.

Relative Value Study (RVS)

The Board approved the 1973 Minnesota Relative Value Study as the basis for an Illinois RVS and a recommendation that references to follow-up care days from the 1974 California RVS be incorporated into the Illinois version. The Council on Affiliate Societies will review and comment on the Minnesota RVS and legal counsel will prepare introductory remarks to be published in the Illinois version to avoid federal anti-trust action resulting from an interpretation that an RVS implies a fee schedule.

Minimum Standards for Health Insurance Programs

A set of minimum standards for health insurance programs—developed by the Illinois Foundation for Medical Care and endorsed by the ISMS Council on Economics and Peer Review and the Council on Affiliate Societies—was adopted by the Board. These standards include general guidelines for basic, excess major medical and comprehensive major medical group insurance programs; required medical coverage; required hospital coverage; required supplemental accident coverage; required radiology and laboratory coverage for professional services only; required out-patient x-ray and laboratory tests; optional changes or additions to basic coverage; required surgical coverage and surgical exclusions; minimum standards for major medical group insurance programs; minimum standards for comprehensive major medical insurance programs; maternity benefits; outpatient psychiatric benefits; exceptions and other possible exclusions and limits.

MD Service Charges on Delinquent Accounts

Physicians making a service charge on delinquent accounts are advised that this charge should not exceed the actual administrative costs of re-billing and

that patients should be notifed in advance that such charge will be added to the bills. Legal counsel advised the Board of Trustees that this practice, previously approved by the AMA, complies with Illinois law.

Electroconvulsive Therapy

ISMS will ask the AMA to oppose, in principle, any actions grouping electroconvulsive therapy with psychosurgery, subjecting it to inappropriate legislative control.

Emergency Medical Care

The Council on Social and Medical Services will explore the feasibility of developing a packet of emergency medical care materials which could be used in public education programs. The packets would be made available to county medical societies wishing to cooperate with community groups in implementing such educational programs.

Amendments to Constitution & Bylaws

The Board requested withdrawal of Resolution 75A-4, which was intended to clarify dues delinquency dates in the bylaws, and referred the matter back to the Committee on Constitution and Bylaws for further study. Also referred back to the committee were recommendations regarding the seating of AMA delegates. Changes in the AMA bylaws will allow state medical societies to seat delegates at the next meeting following their election rather than wait until the following January 1. The Board also endorsed Resolution 75A-27 calling for a constitutional amendment that would eliminate the requirement for conducting a scientific program in conjunction with the ISMS annual meeting.

Medichek

ISMS will help the Illinois Department of Public Health to develop a more acceptable screening form for the Medichek program, which was commended by the Board for its efforts in setting up a computer data system capable of retrieving significant information about the medical care provided every child treated under the program.

VD Treatment Regulations

ISMS will object to the Ill. Depart. of Public Health's restrictive controls over VD treatment. It was reported that in one area of Chicago IDPH will pay for such treatment only if performed in one hospital facility which is available to patients for only a few hours one day per week.

Unified Membership

The Board officially reaffirmed its support of the principle of unified membership.

Blood Pressure Program

The Board endorsed the Illinois Program to Control High Blood Pressure, a registry to keep track of citizens with elevated pressures.

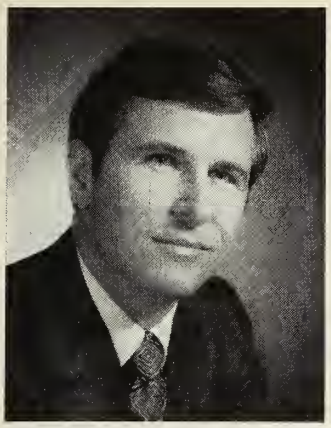
IFMC Board Elections

In their capacity as individual administrative members of the Ill. Foundation for Medical Care, the ISMS Board of Trustees elected Drs. Joseph L. Bordenave, Willard C. Scrivner and Philip G. Thomsen to succeed themselves on the IFMC Board of Directors. Dr. Quentin Kling, an osteopath, was elected to replace Dr. Robert T. Fox. All are three year terms.

Head and Neck Radiation

An ISMS-IHA Joint Committee on Thyroid Neoplasms Associated with Head and Neck X-Radiation informed the Board that it is conducting an education campaign calling attention to the increased risk of thyroid carcinoma resulting from irradiation therapy administered to the head and neck during childhood and adolescence. Chaired by Dr. Fredric Lake, ISMS president, and F. Regis Kenna, Director

(Continued on page 477)



President's Page

ADVOCACY AND ACTIVISM

After watching the development of government programs during the past decade, I am finally convinced that bureaucratic planners and developers are dedicated to creating "monuments," not programs which benefit the individual patient.

Many of these programs actually interfere with, rather than aid, our ability to provide high quality care. We have an obligation to oppose any program which is detrimental to patient care; just as we—the only true advocates of patient well being—have an obligation to insure that programs which benefit individual patients are incorporated into the health care system.

If we are to assume, in a more vigorous manner, a position as advocate for our patients' welfare, we must expose the hypocrisy that exists in the use of political rhetoric for deciding the future course of medical care. We must expose the hypocrisy that occurs with the use of impersonal, dehumanizing statistical averages to predicate the future course of medical care for the individual. We must speak to the hypocrisy that allows a legislator to take the tax dollars of his constituents—who also are our patients—and give it to a medical school to train physicians, and then claim no responsibility when physicians are not forthcoming for bedside medical care.

We cannot stand quietly by while an insensitive statistical study is accomplished that declares a hospital—such as the one in Lawrenceville—must be closed because it makes a better looking plan and service area. And, we cannot stand by and ignore the hypocrisy that allows the same governmental agencies to then attack the medical profession as the cause for the absence of physicians at the bedside in that area.

If I am to speak out on your behalf in these areas and to actively agitate for your demands for increased input in these areas, it is imperative that our action be based on performance, not upon our desires for continuation of outmoded status quo.

To remain passive and ignore our opportunities to guide those who initiate these programs is something we must avoid. I seek your help, suggestions, advice and *involvement.*

J. M. Ingalls, M.D.

J. M. Ingalls, M.D.



medical legal review

Remarks prepared far the canference an *Malpractice and the Dactar Defendant,* presented at the Illinais State Medical Saciety's annual meeting and clinical canference, Thursday, April 3, 1975. Presented by Mr. Jahn Stimpsan, Jahnsan and Higgins af Illinais.

This addresses itself to the subject of medical malpractice and the doctor defendant and the insurance industry's relationship to the concerns of physicians. Familiar themes continue to be heard as particular interest groups search for understanding, equity and relief from special concerns. "The problem," some might say, "is that insurance premiums are too high." Or, "get rid of the lawyer's contingency fees." Others echo that those who suffer injury deserve compensation. Still others plea for medicine's return to the good old days when patients who got sick were treated by friendly doctors who got results and professional negligence suits were rare indeed.

The role of insurance is conceptually simple and familiar to all. If individuals are exposed to risk an insurance company may spread the total exposure among a large group. The effect is to reduce an unknown, and unpredictable financial exposure, to an annual expense or premium. It sounds simple, but it's not. To stay in business, the insurance company must take in enough dollars today to pay all the losses and expenses that will be charged against those dollars in the future. Historically, insurance companies writing medical liability protection for doctors and hospitals have been woefully inaccurate in their projections. They have consistently underestimated the ultimate dollar value of claims. Adequate premiums have not been collected soon enough. Actually, the result has been that doctors have been subsidized by insurance companies for several years.

Today the insurance industry faces challenging problems. Inflation, recession, and an unpredictible stock market, have made successful investment of funds difficult. The conservative ratio of premium income to policyholder's surplus traditionally prescribed by analysts has inflated. This has been especially frustrating for underwriters and actuaries endeavoring to accurately predict ultimate losses. Their concerns are essentially twofold.

First, for every one hundred physicians insured in a given policy year, how many claims will eventually surface from that year's practice of medicine? Diabolically, the illustrative curve has been hyperbolic in its assent.

Second, estimates must be made concerning the size of awards. The value of an unanticipated medical event is far from static. Pain and suffering are unpredictably compensable. The first million dollar medical liability judgements in Illinois were made in 1974. Thus, severity, along with frequency, exploded past projections made by insurance underwriters. Shell shocked, and suffering some staggering losses, the insurance industry found itself with few options.

Generally faced with unsatisfactory results in total book of business and little prospect of improving their medical negligence experience, some companies have elected to withdraw—to give up medical professional liability. For those companies that remain, the burden has become more difficult. Adequate rate levels must be obtained in the face of mounting pressures to keep rates down. Various torsions have been applied on the remaining carriers to accept the undesirable and latent high risk. When profit potential diminishes, competition fades. The result is only too familiar—a crisis manifested by insurance being difficult or impossible to obtain, and rapidly escalating premiums.

Unfortunately, the role of insurance and the industry is often misunderstood. We didn't create the problem, nor can we be expected to solve it. The insurance industry's job is to respond to a risk situation. If reasonable evaluation of the loss potential, in terms of dollars, can be made, rates and policies can be established and written. But if accurate statistics are not available, if the social viewpoint of medical liability is changing so rapidly that no-fault reparations are replacing

the strict doctrines of negligence and tort liability, the crystal ball becomes opaque. Prophesying the future is impossible. For insurance to work, predictability based upon the law of large numbers must exist.

Hopefully the picture drawn has given a better understanding of the insurance industry's difficulty in coping with this problem. Let's explore some of the possible avenues that could lead to an eventual solution.

I believe that every one with a stake in this dilemma must recognize and accept that two values are primary. The quality of medicine in our society must continue its ever increasing level of excellence, otherwise all society will ultimately suffer. In addition, equity for all parties must be established. An adversary relationship between doctors, patients, lawyers and insurance companies must be avoided if progress and results are desired.

Society must decide upon a definition of malpractice. It also must determine what reparations, if any, will become part of society's social obligations to those who suffer physical or financial loss because of unforeseen medical contingencies. The legislature and the courts must define society's wishes with appropriate rules and procedures. The insurance industry must then respond with a funding mechanism for the risks and benefits as defined. But there is the rub. Today's problems were created because the rules were changed; changed gradually and imperceptibly, without the participants becoming aware that new canons had replaced the old. In divining for solutions, this factor of time span must be kept in mind. Anything that will speed up the process of discovery and settlement will reduce the eventual costs. Time span limitations will make the actuary's projections more accurate.

For the insurance industry to respond in proper fashion, it needs a better set of rules and definitions, and differentiation between liability and social compensations. All this may take some time.

The industry, meanwhile, has not been idle nor negligent in its concern over these issues. Efforts at improving the collection of data and statistics is producing more accurate and prompt evaluation. To solve a problem, it is necessary to know what it is and where it exists. Our firm now has a considerable data bank of information that has been immeasurably valuable to us in the administration of several medical liability programs. We believe this information will increase in value as an aid in understanding the complexities involved.

Recently, a California insurance company surveyed medical negligence claims closed in four different states during the past five years. Several recommedations have grown out of this study that every state might wish to consider.

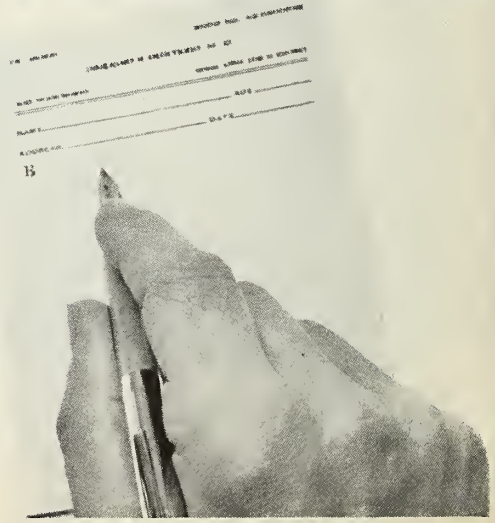
- Adoption of the "New Jersey Rule" providing sliding scale contingency fees;
- Statutory authorization to allow "structured settlements." This would satisfy a claimant's just needs, but bar "windfall enrichment" of heirs;
- Reduction of verdicts by collateral benefits received;
- Legislative definition of informed consent;
- Abolition of "res ipsa loquitur."

The insurance policy itself is being carefully examined. There are those who believe a change from the more common "occurrence" form to the "claims made" basis should take place immediately. One major company has already announced its adoption of the claims made policy for all medical liability written. Lloyd's has offered insurance on this basis for years. However, changing the form will not solve the problem, but it should make it easier for insurance companies to price their product. This might attract more of them into the market; in reality it is a different financing technique. The problem still exists. The concept of paying claims based upon proven liability has been perverted.

There have been other segments of the insurance industry studying proposed legislation on both national and state levels. Underwriting pools, reinsurance groups, no-fault compensation, arbitration and several other possible bromides all are being examined carefully. No single solution appears likely. Undoubtedly, several factors will contribute to the ultimate answer. Uniformity between states, at least initially, seems unlikely. However, as legislative action brings gradual relief, the most successful solutions will be adopted or modified. Lurking in the wings are Federal proposals that could dramatically alter the social system and the delivery of health care in the United States.

Many very bright and experienced insurance men are devoting untold hours in the search for solutions. Actuaries, lawyers, underwriters, claims men and reinsurance specialists are working hard with all concerned. We know a great deal more about medicine, the law, the consumer, and social dynamics than we did just a few years ago. We are dedicated and involved. We are committed to uphold our responsibilities to society and free enterprise. Relief will be forthcoming. Only the form and the timing are in doubt.

Bioequivalence



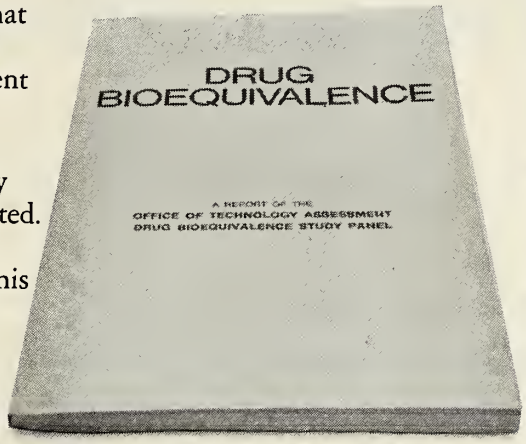
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and (b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or (c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

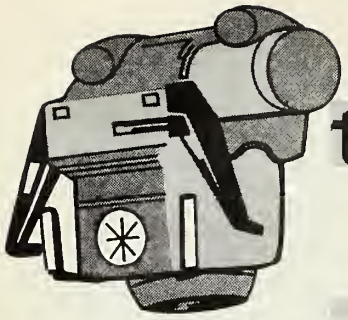
The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription



the view box

Leon Love, M.D./Chairman/Department of Radiology
Loyola University Stritch School of Medicine

This patient is a 26-year-old male who was snowmobiling when he struck a chain running across his path. He was admitted to the hospital with signs of paraplegia. *What's your diagnosis?*



Figure 1

(Continued on page 482)

EF SUMMARY
full prescribing information, see package
lar.)
MARIN®
njugated Estrogens Tablets, U.S.P.)

dications: Based on a review of EMARIN Tablets by the National Acad-y of Sciences-National Research Council d/or other information, FDA has classified e indications for use as follows:
ective: As replacement therapy for nat-lly occurring or surgically induced estro-n deficiency states associated with: the cli-cteric, including the menopausal syndrome d postmenopause; senile vaginitis and urosis vulvae, with or without pruritus.
robably" effective: For estrogen defi-ncy-induced osteoporosis, and only when d in conjunction with other important erapeutic measures such as diet, calcium, ysiotherapy, and good general health-omoting measures. Final classification of s indication requires further investigation.

raindications: Short acting estrogens are raindicated in patients with (1) markedly ired liver function; (2) known or suspected noma of the breast, except those cases of ressing disease not amenable to surgery or iation occurring in women who are at least rs postmenopausal; (3) known or suspected gen-dependent neoplasia, such as carci-a of the endometrium; (4) thromboembolic ders, thrombophlebitis, cerebral embolism, patients with a past history of these condi-; (5) undiagnosed abnormal genital bleeding.
nings: Estrogen therapy should not be given omen with recurrent chronic mastitis or ab-nal mammograms except, if in the opinion of hysician, it is warranted despite the possibil-aggravation of the mastitis or stimulation diagnosed estrogen-dependent neoplasia.
ne physician should be alert to the earliest festations of thrombotic disorders (throm-lebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:

nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. 7352

PREMARIN®

AND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

Education Campaign Focuses on Effects of Irradiation Therapy

A joint committee of ISMS and the Illinois Hospital Association (IHA), with representatives from the Chicago Medical Society, Chicago Hospital Council, Illinois Division-American Cancer Society and Chicago and Illinois Radiological Societies, recently launched an education campaign calling attention to the increased risk of thyroid carcinoma resulting from irradiation therapy administered to the head and neck during childhood or adolescence.

The campaign is designed to inform physicians and hospitals of the problem and to advise the public that patients who received irradiation treatments—between the 1930s and early '60s—should have a thyroid examination.

Irradiation therapy to shrink tonsils, adenoids and thymus glands and to treat other benign conditions has increased the incidence of thyroid cancer. Although irradiation therapy has been discontinued for at least 15 years, the late effects of this treatment are being reported with increasing frequency. Some reports indicate that the high incidence of thyroid nodules, both benign and malignant, may appear as much as 25 years or later after the irradiation treatment. Researchers found a seven percent incidence of carcinoma in an unselected group of 100 patients with a history of neck irradiation.

In an effort to provide detailed information which would allay public anxiety and insure proper management, the following actions were taken: (1) ISMS distributed to all Illinois physicians an explanation of the problem and suggested guidelines; (2) IHA distributed to all Illinois hospitals an explanation of the problem and suggested guidelines for handling patient inquiries and establishing thyroid screening programs; and (3) Illinois Division-American Cancer Society prepared a "public message" which was the basis for a news release sent to all Illinois media. The news release explained the problem and urged patients to contact their physician for an examination.

Patients in the Chicago area who did not have a physician were urged to contact the Chicago Medical Society's Referral Service or their hospital. Outside the Chicago area, persons without a physician were urged to contact their county medical society or local hospital for referral to a physician.

Following is a list of facilities which are conducting thyroid screening programs:

City	Hospital	Phone Number For Screening Program Inquiries	Cost for Screening	
			Former Patients	Others
Alton	Alton Memorial Hospital	618/462-8851, ext. 306, if no ans. ext. 203-204	No charge	Established fees
Aurora	Copley Memorial Hospital	312/897-6020, ext. 776	No charge	No charge
Carbondale	Doctors Memorial Hospital	618/549-0721, ext. 221	Physician's discretion	Established fees
Chicago	Chicago Osteopathic Hospital	312/363-6800, ext. 401	No charge	Established fees
Chicago	Children's Memorial Hospital	312/649-4500	No charge	Established fees
Chicago	Cook County Hospital	312/633-8971	To be determined	To be determined
Chicago	Holy Cross Hospital	312/HE4-6790	No charge	Established fees
Chicago	Louis A. Weiss Memorial Hospital	312/878-8700, ext. 283	No charge	Established fees
Chicago	Mercy Hospital and Medical Center	312/567-2206	No charge	Established fees
Chicago	Michael Reese Hospital and Medical Center	312/791-2532	No charge	Established fees
Chicago	Mt. Sinai Hospital Medical Center	312/542-2360	No charge	Established fees
Chicago	Northwestern Memorial Hospital and Northwestern University Medical Clinics	312/649-2070	No charge	Established fees
Chicago	Presbyterian-St. Luke's Hospital	312/942-6028	No charge	Program limited to former patients.
Chicago	St. Anne's Hospital	312/378-7100, ext. 225	No charge	Established fees
Chicago	St. Elizabeth's Hospital	312/278-2000, ext. 206	No charge	Established fees

(Continued on page 446)

Editorials



Suing for Barratry

I have no way of knowing how many physicians have read Dr. Hugh A. Johnson's article on malpractice suits that appeared in the December 1974 issue of *IMJ*.[1] Johnson warns that he will sue the plantiff's lawyer if he is threatened by a malpractice suit. He is not sure about the outcome since it has never been done, but there is no harm in trying. Indeed, if the plaintiff's lawyer can threaten the physician into making a settlement, why can't we threaten and sue him for defamation of character?

Dr. Johnson, clinical associate professor of plastic surgery at Rockford School of Medicine in Illinois, has never been sued for malpractice but if he is, he plans to sue the patient's lawyer for barratry (exciting or encouraging lawsuits or quarrels). He's made the stakes high—a million dollars—so that the lawyer would do everything possible to protect his source of income. Dr. Johnson would take his case to the Supreme Court if necessary, and if he won, he would not be forced to share it with his lawyer because his fee would be substantial and it would be paid in advance.

This idea has crossed my mind many times, particularly when the plaintiff's lawyer discourages his client from trying to get well until after the trial is over. By this time, it is usually too late for obtaining a cure and a large share of the client's award has been devoured by legal and other fees.

Presently, there is no easy answer to malpractice litigations. Most physicians would like to see them arbitrated by a special board in much the same way as industrial accidents and illnesses are handled. Any physician who attends medical and staff meetings finds that every one has his own pet solution to the problem. One of the wildest is to put all your earthly wealth in your wife's name and cancel your malpractice insurance. The plaintiff's lawyer gains nothing, even if he wins the case. And, under these circumstances, he is not likely to accept the case on a contingency arrangement.

My thoughts on this will have to stand on their own merits as I am not a lawyer, and I did not see fit to impose on my legal-eagle friends for an opinion.

T. R. Van Dellen, M.D.
Editor

Reference

1. Hugh A. Johnson: "Sue Me, Sue Me!" *Illinois Medical Journal* (Dec) 1974, pg. 549.

IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

Gonorrhea, according to the national Center for Disease Control, is, if the parenteral route is chosen, most effectively treated with aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindications: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Administration and Dosage: Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?



On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population.* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IMJ
Illinois Medical Journal
Vol. 147, No. 5, May, 1975

Hematogenous Osteomyelitis of the Scapula Presenting as Erb's Palsy

By Daniel G. Cunningham, M.D./Oak Lawn

The scapula is a rare site of infection in childhood. It is difficult to find references to hematogenous osteomyelitis of the scapula as a separate clinical entity and thus its clinical manifestations have received little attention. Table I illustrates the fact that scapular involvement occurs in less than one per cent of all cases of osteomyelitis in childhood.[1-11]

The purpose of this article is to alert physicians to an unusual manifestation of osteomyelitis of the scapula in the form of immobility of the arm clinically identical to Erb's paralysis. Of special importance is the fact that this symptom preceeded the clinical and radiographic signs of the underlying bony lesion. The presenting clinical manifestation could have been erroneously attributed to obstetrical or postnatal trauma to the brachial plexus.

Case Report

The patient was a full-term male infant born to a gravida VI mother without obstetrical complications or difficulty at the time of birth. At birth he was found to be healthy, but shortly developed respiratory distress. Radiologic studies of the chest revealed a pneumomediastinum. On the second day of life, a repeat radiologic study of the chest revealed a left sided pneumothorax, in addition to the pneumomediastinum. The clinical course was further complicated by vomiting, and because of this, intravenous fluids were given by umbilical venous catheter. The infant's further progress was satisfactory and oral feedings were tolerated on the fifth day of life.

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On the ninth day of life, radiologic studies of the chest were done and showed complete absorption of the extrapulmonary air. On the tenth day, the infant for the first time was observed to have flaccid paralysis of the left arm. The arm was internally rotated and a flaccid paralysis of the biceps, brachioradialis, and deltoid muscles was noted. A clinical diagnosis of Erb's Paralysis was entertained. There was no sign of local trauma and radiologic studies showed no evidence of a skeletal lesion in the shoulder or cervical area. The infant was discharged on the fourteenth hospital day.

Eight days after discharge a mass over the left shoulder area was observed, and the infant returned for evaluation. Physical examination confirmed the presence of a large fluctuant mass located over the left scapula. A clinical diagnosis of abscess was made, the mass was incised, and a large amount of purulent material was drained. A culture of this material grew staphylococcus

TABLE I
Prevalence of Scapular Involvement in Cases of Osteomyelitis in the Pediatric Age Group

Author	Scapular Involvement	Age Group	Number of Cases of Osteomyelitis
Wade (1929)	0	All Under 13 Yrs.	100
Pyrah, Pain (1933)	0	219 Under 15 Yrs.	262
Santi (1934)	0	Under 1 Yr.	87
Green, Shannon (1936)	0	Under 2 Yrs.	95
Greengard (1946)	1	Under 2 Yrs.	10
Blanche (1952)	2	Infancy	25
White, Dennison (1952)	2	Under 13 Yrs.	212
James (1953)	0	Under 5 Yrs.	40
Potter (1954)	1	Newborn	6
Winters, Cahan (1960)	1	61 Under 15 Yrs.	66
Gilmour (1962)	2	Under 13 Yrs.	328
Total	9	(Under 15 Yrs.)	1,183

aureus, coagulase positive. Radiologic studies revealed an extensive destructive process of the left scapula.

The infant was hospitalized and an intensive course of methacillin was given intravenously. After two days of treatment an improvement in the movements of the arm was observed. In response to treatment the abscess resolved with healing of the overlying skin.

The child was observed over a number of months. The function of the arm returned to normal, and at eighteen months of age the structure and size of the scapula were normal.

Discussion and Conclusion

This infant illustrates the fact that the weakness of the arm can be falsely attributed to an injury to the brachial plexus causing Erb's Paralysis. Though the association of osteomyelitis of the scapula and paralysis of the arm is a rare association, similar clinical findings have been described in the past. Fardon[12] described an infant with osteomyelitis of the scapula in whom immobility of the shoulder was part of the clinical picture. A similar association was also noted by Blanche[6] in one of his cases of osteomyelitis of the shoulder. Obviously, this association is not common, but once the association is recognized, the condition can be treated promptly so as to prevent excessive bony destruction and perhaps permanent injury to the patient. A similar clinical picture has been observed in cases of infantile cortical hyperostosis (Caffey's Disease) involving the scapula in the early months of childhood.[13]

No theories are presented here as to the pathogenesis of the weakness of the arm movements. Perhaps in future cases nerve conductivity studies would be of value to determine whether this represents a true neuritis or a form of pseudoparalysis due to local factors such as edema or discomfort. ◄

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Congenital Absence of Left Pulmonary Artery

By Raymond A. Dieter, Jr., M.D., Frederick C. Kuharich, M.D./Glen Ellyn

Congenital pulmonary abnormalities of the vascular system are not unusual. Pulmonary artery stenosis is occasionally seen. Aberrant pulmonary artery origin from the ductus arteriosus or from the aorta does occur.[1-3] *Although pulmonary vascular abnormalities are not rare, the congenital absence of a pulmonary artery without other cardiac abnormalities is extremely uncommon. In fact, only 40 such cases have been located in the literature.*[4] *Herein described is an additional patient with congenital absence of the main left pulmonary artery and recurrent respiratory symptoms.*

Case Report

M. R., a 21 year old white female, was essentially seen on June 16, 1970 because of recurrent upper respiratory symptoms. When first seen, she had a temperature of 99°F., nasal congestion, soreness in her throat, stuffiness in her head of several days duration, and an increase in her cough and shortness of breath. Her temperature had been 102°F. at home. Scattered rhonchi were heard especially in the right lung. There was some wheezing noted. Two days later, she still was coughing and was short of breath. Her temperature was 102°F. The chest X-ray demonstrated tracheal deviation to the left with no infiltration.

In 1966 at the age of 17, on admission to a hospital in Wisconsin, chest X-rays demonstrated mediastinal deviation to the left. At the age of 18, when her tonsils were removed, an X-ray of the chest was also interpreted as showing a mediastinal deviation. No further work-up was performed. Her family physician had seen her on nine occasions during the past seven years because of respiratory difficulty. One year prior to the present admission she was told she had walking pneumonia and pleurisy. In 1964, she was also treated for pneumonia. She smoked one-half pack of cigarettes per day and was on thyroid extract and Norinyl.

Physical examination demonstrated tracheal deviation to the left, diminished breath sounds over the left chest, harsh breath sounds over the right chest, a slightly smaller left chest as compared to the right, and some left anterior rib soreness. There was increased vocal and tactile fremitus noted on the right. No murmurs and no thrills were found.

Roentgenograms of the chest revealed a reduced volume in the left hemithorax, a mild deformity in the left rib cage, a shift of the heart and mediastinal structure to the left, and a mild elevation of the left diaphragm (Fig 1). The right lung appeared to be slightly overexpanded and crossed the midline through the anterior mediastinum. The pulmonary artery shadow on the left was absent. Tomograms demonstrated the phrenic vessels to be quite dilated and to cross the diaphragm and enter the parenchyma of the left lung. At bronchoscopy, the trachea was deviated to the left. The left main stem bronchus contained thick white tenacious material. There was a normal bronchial distribu-

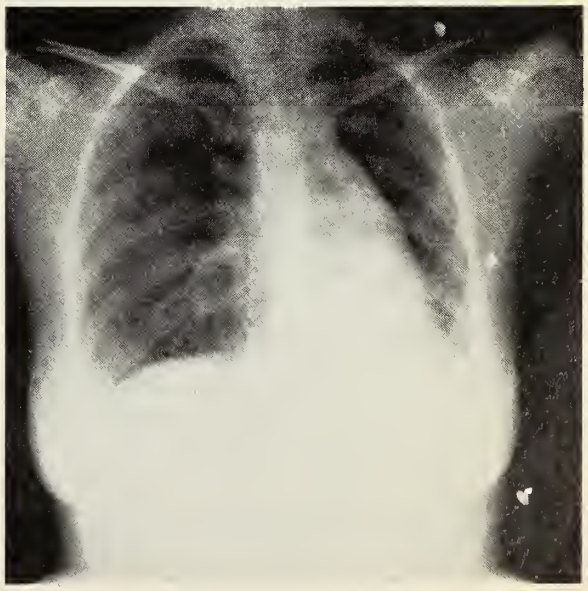


Figure 1. Chest X-ray.

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FREDERICK C. KUHARICH, M.D., is an internist at the Glen Ellyn Clinic. He was trained at Northwestern University and St. Joseph's Hospital of Chicago. A residency was taken at St. Joseph's Hospital from 1949-50 and at Hines V.A. Hospital from 1951-53. A fellowship was taken at Cook County Hospital in Pathology.

tion on the left. The right main stem bronchus was deviated upward. There was slight reddening in the right main stem bronchus and mild narrowing of the right bronchus intermedius. The right upper lobe revealed a bifurcating bronchus. Initially, the chest X-ray revealed bilateral lower lobe infiltrates, especially on the left. These cleared.

A pulmonary scan was performed using I^{131} labelled albumin. The anterior and posterior lung scan revealed total absence of I^{131} perfusion to the left lung (Fig. 2). The right lung showed normal perfusion. Cytology revealed atypical cells with bacterial clumps. The aortic arch was noted to the right of the esophagus on barium swallow and angiography. Electrocardiogram was normal. Pulmonary function studies demonstrated a mild to moderate restrictive ventilatory abnormality without a significant obstruction.

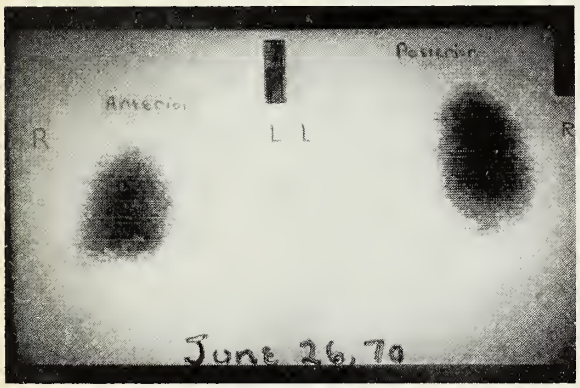


Figure 2. Pulmonary Scan.

(Table I). Right and left heart catheterization, pulmonary angiography and thoracic aortography was performed through the right arm. The pulmonary arteriogram showed complete absence of the proximal left pulmonary artery with a smooth main pulmonary artery. (Fig. 3). No aortopulmonary shunt was noted. The hemodynamic studies were normal. (Table II).

Discussion

A 21 year old white female with congenital unilateral pulmonary artery absence and a right aortic arch is presented. She had repeated respiratroy infections over the past seven to eight years. As a result of these, a tonsillectomy was performed three years prior to the present study with no symptomatic improvement. Chest X-rays taken on several occasions were interpreted as revealing either a normal chest or a mediastinal deviation to the left of unknown etiology.

Isolated absence of a pulmonary artery is very unusual. In fact, only 40 such cases have been

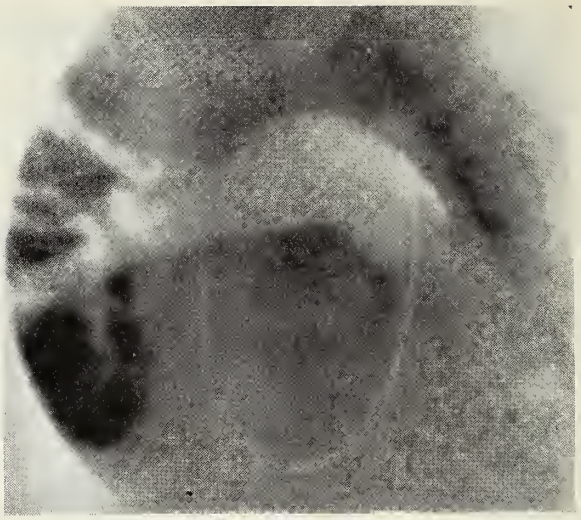


Figure 3. Pulmonary Angiogram.

reported in the literature.[4] It is more common to have this lesion in association with other congenital cardiovascular anomalies, especially tetralogy of Fallot. An embryologic interpretation of the etiology of this congenital defect was discussed by Anderson, et al, in 1958.[5] Symptoms vary from complete lack of any difficulty[6] to hemoptysis,[7] infection and pulmonary hypertension.[8] Normal resting pulmonary artery pressure is the usual finding in older individuals. However, in infants, with this anomaly proven at autopsy, severe and rapidly fatal pulmonary hypertension has developed.[9] This may be related to the increased flow load of twice normal to the good lung. Bronchiectasis has developed in these patients. The bronchogram on this individual failed to reveal any such abnormality. The aortic arch is usually on the side opposite to the absent pulmonary artery.



Figure 4. Aortogram.

TABLE I
Pulmonary Function Studies
Height: 61 Ins/ 156 Cm, Weight: 140 lbs/ 63 Kg. Surface area: 1.63 m2

	Normal	Before Bronchodilator	After Bronchodilator
Vital Capacity	3.3 L	⮟ 2.6 L	2.6 L
% Normal V.C.	80%	⮟ 79%	79%
Inspiratory Capacity	2.5 L	⮟ 1.7 L	1.8 L
IC			
VC x 100	70-80%	⮟ 65%	69%
Expiratory Reserve	0.84 L	⮟ 0.90 L	0.77 L
ER			
VC x 100	20-80%	35%	30%
Residual Volume	1.2 L	⮝ 1.5 L	1.2 L
RV			
TLC x 100	26%	⮝ 37%	32%
Functional Residual Capacity	2.4 L	2.4 L	2.0 L
Total Lung Capacity	4.5 L	⮟ 4.1 L	3.8 L
		MECHANICS	
Vital capacity in 1 sec.	3.8 L	⮟ 2.0 L	2.1 L
% Vital Capacity in 1 sec.	70%	⮟ 77%	81%
Max. Mid-expiratory Flow	3.8 L/sec.	⮟ 1.8 L/sec.	1.9 L/sec.
Max. Mid-expiratory % normal		⮟ 47%	50%
Max. Breathing Capacity	101 L/min.	⮟ 76 L/min.	79 L/min.
Max. Breathing Cap. % normal	80%	⮟ 75%	78%
		DISTRIBUTION	
Shape of Washout Curve		Normal	Patient
Helium mixing efficiency, min.		1.5-3.0	2.5/3.5
Helium mixing efficiency %		70%	80%/79%

One must be careful in the diagnosis of this lesion to distinguish between unilateral pulmonary agenesis (or hypoplasia) and unilateral pulmonary artery absence. In addition, this lesion should be kept in mind when establishing the diagnosis of congenital cyanotic heart disease and pulmonary hypertension. Other lesions which might immitate unilateral pulmonary artery absence include unilaterial emphysema, bronchiectasis, coarctation of the pulmonary artery, massive pulmonary artery embolus or thrombosis. In this individual, pulmonary embolism was initially considered because of the recent controversy concerning the estrogen compounds (the "pill"). Previous films discarded this diagnosis.

Treatment has not led to a high degree of success. One must be cognizant of the increased blood supply to the involved lung from the ascending aorta and the bronchial arteries. In addition, the phrenic vessels may be rather large. This patient demonstrated both. To do a lateral thoracotomy, one should expect a marked degree of bleeding. There has also been complete synthesis of the pleura reported with this condition.[5] Recently, Green, et al, reported surgical correction of such a lesion by direct anastomosis of the distal left pulmonary artery and the main pulmonary artery.[10] The child had sufficient flow through a ductus arteriosus to outline posterolateral thoracotomy. Xenon photoscanning of such a lesion in the future would be of value.[11]

The prognosis in the adult patient appears to be good. The pulmonary arterial pressure seems to depend entirely on the status of the intact lung, providing infection and hemorrhage in the diseased lung remains controlled. This patient will be followed closely and treated with antibiotics for recurrence of symptoms. Furthermore, she has been advised to stop smoking and not to move to high altitudes.

Summary

The case history of a 21 year old white female with recurrent respiratory difficulties for many
(Continued on page 492)

surgical grand rounds

Edited By John M. Beal, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion. Patient presentations from Passavant and Wesley Pavilions of the Northwestern Memorial Hospital and the Veterans Administration Research Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of May 23, 1972.

Subclavian Vein Thrombosis

Dr. David Bruce: A 40-year-old white woman was admitted to Passavant Memorial Hospital with a chief complaint of pain and swelling in her right arm of one week's duration. Seven days before admission, an aching sensation was noted in the right arm, and by the next day, marked swelling in this arm had developed which she described as about twice normal size. This was associated with tenderness, particularly in the axillary area. There was some redness in the limb which blushed, particularly dependent. She also noted marked dilation of the superficial veins in her arm. She had attempted to obtain relief by elevation of the upper extremity which resulted in some decrease in the swelling. However, persistence of the pain and loss of mobility of the arm caused her to seek medical attention.

Past history included the use of birth control pills for seven years prior to the onset of her symptoms and she had finished her last menstrual cycle two days before symptoms developed. In addition, she had initiated vigorous arm exercises before the onset of her symptoms. She denied previous vascular problems, facial swelling, calf tenderness or swelling, chest pain, shortness of breath, hemoptysis, fever or chills.

Physical examination at the time of admission demonstrated a well-developed, well-nourished white woman with vital signs within normal limits except for an oral temperature of 99°F. Physical examination was otherwise within normal limits except for the right upper extremity. Pulses in all extremities were strong and equal. The neck veins on the right side were distended greater than on the left side when she was supine. Marked swelling on her upper right extremity was apparent, which was red and marked by tender to palpation in the right axillary area, particularly along the course of the brachial vessels. Admission laboratory data: complete blood count urinalysis and SMA-12 were within normal limits. Electrocardiogram and chest X-ray were interpreted as normal. On the day of admission, an emergency venogram was done.

Dr. Abram Cannon: The venogram shows the filling of the brachial vein with a complete obstruction at the axilla. (Figure 1) There is no filling of the axillary or the subclavian veins.

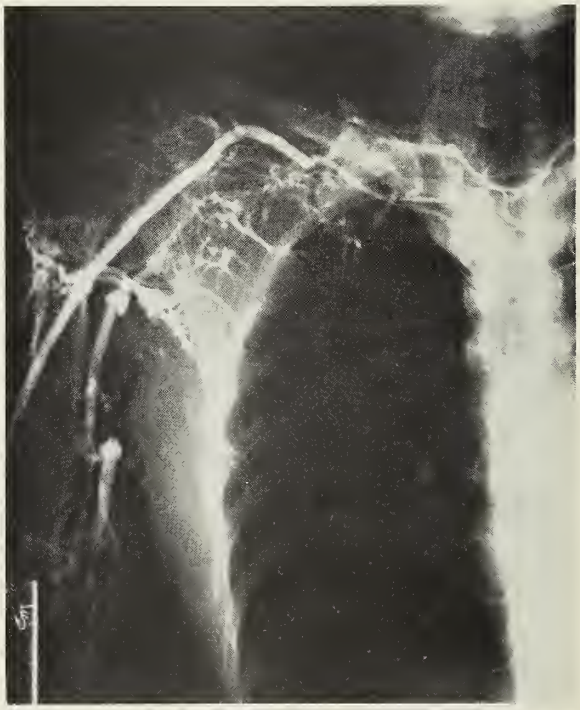


Figure 1. Venogram of right upper extremity demonstrates obstruction in the axilla.

Collateral channels are seen about the cephalic vein extending towards the opposite side. (Figure 2)

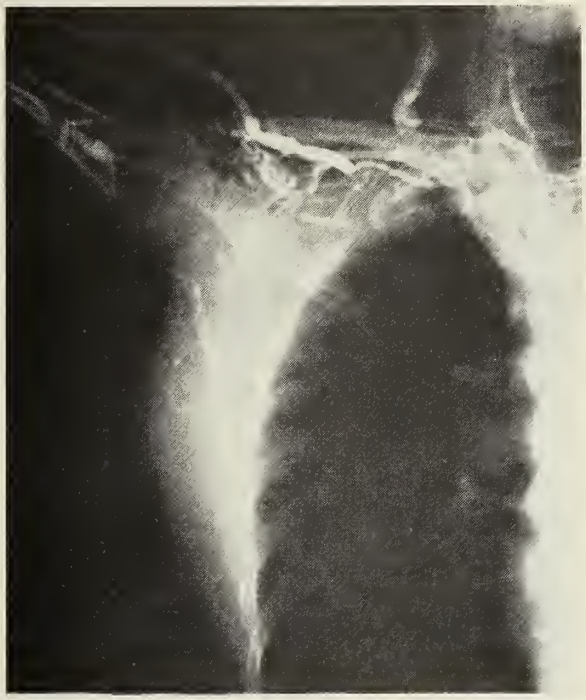


Figure 2. Following elevation of the arm, collateral circulation is apparent with flow extending to the jugular veins and to the opposite side.

Dr. David Bruce: Intravenous heparin therapy was initiated. Within 24 hours, marked decrease in pain was noted associated with decrease in tenderness and swelling. The day after admission, she was studied in the Blood Flow Laboratory at Wesley by Dr. Yao. The findings were consistent with occlusion of the subclavian vein, and confirmed the clinical impression of subclavian and axillary vein occlusion. Heparin therapy was continued for three hospital days at which time oral coumadin therapy was begun. Improvement was progressive and she was discharged without pain or tenderness although mild swelling still persisted.

Dr. Julius Conn, Jr.: This patient presented with a classical history and course for venous occlusion of the upper extremity. She first consulted her family physician who, with the history that she had done arm exercises and had been carrying heavy suitcases while on vacation, felt that her pain was musculoskeletal. When the pain persisted and she began to develop swelling, and she had failed to respond to local therapy, he referred her for vascular consultation.

Phlebitis in the upper extremities, excluding chemical phlebitis following intravenous therapy, accounts for approximately 1% of all the cases of deep thrombophlebitis. It is a disease that is not very common and is, therefore, not often thought of. For some unknown reason, embolization from the arms is extremely rare.

Patients with subclavian vein thrombosis are usually young males with symptoms most often in the right arm. The phlebitis may be secondary to direct injury to the vein, compression by a tumor mass in the apex of the lung, infection in the mediastinum, superior vena cava occlusion or perhaps stasis secondary to shock or severe dehydration. There have been cases reported associated with a hypercoagulable state secondary to anovulatory drugs such as this patient was taking. In this case, I think that we have two possible etiologies; one, she may have been prone to thrombosis because of the anovulatory drug therapy and she was just starting a program of arm exercises and, thereby, compressed the vein. For years, subclavian vein thrombosis was known as effort thrombosis.[1] The common etiology now seems to be that many of these people have thoracic outlet compression and compress the subclavian vein, or at least decrease flow in the vein as it crosses the first rib.

With the arm abducted and externally rotated, the lateral edge of the clavicle moves posterior and the medial end of the clavicle shifts down toward the first rib, thereby trapping the subclavian vein against the first rib. Individuals who work with their arm in the abducted position may overdevelop the pectoralis minor muscle and constrict the axillary vein at the point where it crosses under the pectoralis minor and in that way produce venous thromboses.

The treatment of subclavian vein thrombosis is controversial. It has been thought for sometime that these patients could be treated with rest, heat and elevation and they all did well. To the surprise of several vascular groups who carefully analyzed the results of therapy, as many as ¾ of the patients had significant long term disability following an axillary or subclavian vein thrombosis. The disability may not be apparent until the patient has been out of the hospital for one to two months; they then begin to note aching in the arm and peripheral edema especially after activity. Following venous occlusion, if you measure peripheral venous pressure and then exercise the arm, there is a step-wise elevation of the venous pressure. The venous pressure will plateau, but if the exercise continues, the pressure begins to rise again, leading to pain and swelling of the hand and arm. The large collateral veins that develop are frequently inadequate for venous drainage with effort. Recanalization of the

vein lumen occurs less frequently in the upper than in the lower extremity.

The vascular group at the University of Michigan studied patients treated with anticoagulant therapy and found that those treated with heparin early, that is within the first 7 days of onset of the disease, the incidence of long range disability was low, as compared to those treated without anitcoagulation. A third group of patients studied were those anticoagulated late. Delayed anticoagulation did not improve the results. Venous thrombectomy has not improved the long term results of therapy.[2]

In summary, I think that the patient who has subclavian vein thrombosis and minimal signs of thoracic outlet compression should be treated with heparin for 7 to 10 days and then with oral anticoagulant therapy for six to eight weeks to prevent propagation of clots and to allow maximum development of collaterals. If, during this time, they show progression of symptoms of nerve or arterial compression, then, they should have decompression of the thoracic outlet. We have found that the best technique for complete decompression of the outlet is to remove the first rib using the transaxillary approach. Many patients will have intermittent venous occlusion secondary to thoracic outlet compression and will have a great deal of disability from edema of their hands. Dr. Yao is going to discuss this when he presents the flow studies. Perhaps these flow studies will, in time, supplement or even do away with the need for venography. One last point, as a safeguard when performing the venography, in order to decrease the incidence of superficial phlebitis, we flush the vein thoroughly with 500 cc of saline containing 5,000 units of heparin in an attempt to decrease the irritant effect of the contrast agent.

Dr. John M. Beal: Dr. Yao, please explain the studies that you performed and their significance.

Dr. S. T. Yao: It is important to differentiate between intermittent compression of the subclavian vein and subclavian vein thrombosis. The Doppler ultrasound transcutaneous flow detection method is ideal in this situation. In addition, we measure venous pressue at rest and during exercise. Venous flow velocity and pressure are then measured under various thoracic outlet maneuvers.

In normal subjects, venous flow velocity changes with respiratory cycles. During Valsalva maneuver, flow ceases, venous pressure is steady, and no flow velocity is recorded. With sudden release of the intra-thoracic pressure, there is a rapid fall-off of venous pressure in the leg and a very high-velocity signal is recorded. When flow velocity is recorded distal to an occlusion (thrombosis), no respiratory waves are seen. Flow velocity is continuous and venous pressure is elevated. Breath-holding does not completely stop the flow and there is no increase in pressure. On release of intrathoracic pressure, there is no change in flow velocity. During exercise, a steady increase of venous pressure is commonly seen, together with a decrease in flow velocity.

Intermittent compression of the subclavian vein, occurring only during hyperabduction, will be manifested by an abrupt cease of venous flow, elevation of venous pressure, and steady increase in venous pressure during exercise when the patient is examined in this position. We recently encountered a patient with these findings at the Chicago Wesley Memorial Hospital. Subsequent venography confirmed the ultrasound and venous pressure findings.

We believe such measurements are helpful in determining the effect of positional changes of the thoracic outlet upon venous flow velocity, and allow a better radiological and surgical approach to this rather uncommon disorder.

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Irradiation Therapy

(Continued from page 430)

Chicago	St. Mary of Nazareth Hospital	312/292-5295	No charge	Established fees
Chicago	University of Chicago Hospitals and Clinics	312/947-6391	No charge	Established fees
Chicago Heights	St. James Hospital	312/756-1000, ext. Radiation screening office	No charge	No charge
Elmhurst	Memorial Hospital of DuPage County	312/833-1400, ext. 735	No charge	Established fees
Evanston	Evanston Hospital	312/492-3980	No charge	No charge
Evergreen Park	Little Company of Mary Hospital	312/422-6200, ext. Radiology Department	No charge	Program limited to former patients.
Harvey	Ingalls Memorial Hospital	312/339-7502	No charge	Established fees
Mattoon	Memorial Hospital	217/234-8881, ext. 29	No charge	Established fees
Melrose Park	Westlake Community Hospital	312/681-3000, ext. 268	No charge	Established fees
Springfield	Memorial Medical Center	217/528-2041, ext. 480	No charge	Established fees
Springfield	St. Johns Hospital	217/544-6464, ext. 280	No charge	Established fees

How Not to be a Retirement "Drop-Out"*

By Bertram B. Moss, M.D./Chicago

The proper question is, "When does one start making retirement plans?" The answer is,—at the prime of life, the pinnacle of middle age. Middle age occurs at the end of rearing children. It occurs for the working man before he reaches his level of incompetence. It occurs when the worker is still in power—making decisions. Middle age is when every thing starts to wear out, fall out, or spread out!

Middle age is evidenced by an increase of emotional reactions to such previously enjoyable time designating events as christenings, confirmations, marriages. The middle aged person begins to observe physical changes in his body, he begins to think of, and have a fear of death. The fountain of youth concept begins to seem appealing. There is some increasing panic in the search for the elusive Shangra-la, where one is supposed to enjoy the rest of your life. Middle age occurs at the time when one begins to reassess his lifestyle—the way one lives, the marriage, the career, the self-esteem or esteem felt by others. At the time of middle age, the 40 to 50 year old begins to claim he needs, one more last chance. A person self conscious of middle age may begin to drink a little more and get a little more depressed.

At the time of middle age new and different sexual fantasies become more common. Religion often becomes more important. Certain denial mechanisms of the aging process become evident with rationalizations, fixations, rigidity, fatalistic, cynical, pessimistic, or optimistic ideations. Suddenly old people and young people seem further apart and the already serious generation gap widens even more.

At the time of middle age we often begin to detect signs of aging. A frank gerontophobia or bigoted fear of elderly persons may become evident. Some people even develop an overt hostility toward the elderly, handicapped, or very poor, who appear to be the non-productive members of our society.

Executive Change of Life

The middle age "blas," or "middlesence" has to be considered a crisis period of life. It is predominately common among executives, and was formerly called *change of life*. The effects are traumatic and often debilitating for the individual, his family and his working organization. Middlesence is rampant among those we used to call bureaucrats, now labelled technocrats because of their special skills and talents.

The bureaucrat was the middle management man who rose to executive position either by attrition or by being in the right place at the right time. The technocrat rose to prominence by quick ascendancy through middle management on a fast-track. Middlesence, can slow down the plodding bureaucrat with little observable effect. The effects of middlesence on the fast-track technocrat are observable derailment, disillusionment, and dispiritedness.

Retire To Something

Whenever somebody tells me he's about ready to retire, I always ask him, "What are you going to retire to . . . and where?" Only 5% of the elderly will drop-out and retire to an institution. Still long-term-care facilities must provide the where and the what to which people retire in a congregate setting.

Most of those over 65 will retire to independent activities in the general community. Some will drop-out because of being home-bound or severely limited in activities. The successful retirees in our general community are usually active and functioning both physically and mentally. They are the survivors; the winners; the successes. They are tough to hold down, almost impossible to wipe-out. Most of them are bright, they think fast, and can deal with most any situation. They never seem to quit, they outlast others, they survive all crises. These winners do everything, they try everything, but always in moderation. They operate on a small and unspectacular scale—but always successfully. They are the big fish in the small sea. Almost universally they possess outstanding talents, skills and instincts.

The institutionalized (5%) survivors are often incontinent, crotchety, cantankerous, suspicious, and demanding of others. They are mostly aggressive, irritating, narcissistic, critical, negative, and complaining, Many have a pugnacious, daring stance toward the world. But, who is going to

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*Address presented to Woman's Auxiliary of the Illinois State Medical Society, March, 1974.

argue with the successful survivors, even if they need a congregate setting to survive? They have dropped-out of the general community, but are successful retirees in the institutionalized community.

Retirement in the community or in an institution must not discontinue one's useful activity. Retire to anything you choose—fishing, reading, work, golf, travel, religion, community work, but don't retire into a rocking chair and then complain about not having anything to do.

Adjustment

We find the greatest problem in adjusting to retirement occurs not in the first few weeks, but several months after a man has left his job. Partly, it's because of our inability to project ourselves realistically into the future. When you were ten years old, did you anticipate the agonies of adolescence? When you were courting or being courted, did you fully realize the nature of marriage and parenthood? Do you now view your present job in the same light as when you first started it? Experience is indeed a great teacher, and while we can plan for the future, we must eventually adjust to the realities we encounter there.

It might come as quite a shock, for example, if you find that your role as head of the family depended only upon being a breadwinner. You may be startled to find that you are now given advice as to how you should spend your time, your money and your emotional reserves. Too many people automatically take over the life-planning of a retired person, as though he were suddenly incapable of making his own decisions. Some families reverse the child-parent roles at the 65th birthday party.

There are usually three stages in adapting to retirement. First, for a relatively brief time, there is a feeling of escape from having to punch a time clock or keeping up a steady round of appointments. Men who have been looking forward to sleeping till noon get up earlier than ever. Others gloat about never having to be places on time again but become more punctual than ever when there's nothing to delay them. In this early project stage, the retired man will spend hours fishing, reading, or fixing up his house, or doing all those things he has been looking forward to.

However, he soon realizes that these are only temporary occupations, and he begins to search for something more satisfying. He suddenly realizes that he doesn't have a job. He faces the full implication of a sharply reduced income, the absence of a daily work pattern, and a loss of contact with his fellow workers. He has established a lifelong pattern of getting up at a certain time, playing the heavy in a certain role, being at a specific place at a given time, washing, dressing, eating, and sleeping. This rut is now ended, and he must consciously create a new routine or life pattern to replace the old. He begins a belated search for his Shangra-la. With a maximum of support by all members of his family, this period of aimless drifting must be worked through to the third stage, in which the retired person adjusts to the situation and finds new goals and satisfactions. If he has not already made his retirement plans, he finds himself frozen in this untenable situation.

However, if there is any suggestion during the second period that he is through, finished, washed up, the retired person may feel outcast and unattractive, and never proceed to the final stage. He may simply bemoan his plight, and agonize over his lack of pre-retirement planning. One of the best ways to avoid this is to seek professional help. Not during the first few weeks of retirement, but a couple of months later. He can be shown how much he is needed, by being given a continuing responsibility. It may not be a major one, but it must be real in his acutely sensitive condition. He will quickly recognize and reject even the kindest of deceptions. He may appreciate concern, but his feeling of being unneeded may be even further increased.

This can't be a one-shot effort, a week after the retirement party. It is one of our too-human habits to rally around a person at the time of crisis, and then gradually leave him alone when the panic is over. This fails to take one important thing into consideration: the crisis itself may generate enough excitement to carry the person through it. But when everyone leaves and the reaction sets in, he finds himself without help at a time of real need for reassurance and comfort. The retiree at this point may feel all alone, bewildered, confused and guilty about not having prepared himself.

With continuing help however, the retired person proceeds to the final stage of adjustment and finds occupations and new interests that will provide him with:

- a place for social participation, which the office or shop has provided up to now, to some extent;
- a source of satisfaction and achievement;
- a means of passing time without boredom; and
- a feeling of usefulness, of being cared about, and of recognition for achievement.

The Distaff Side

Retirement can by no means be considered exclusively a male problem, since 40 percent of

American women thirty-four to sixty-four years of age are in the labor force. This number is expected to rise, even though women tend to retire earlier than men. When women leave the job, they go through much of the same "letdown" as their male counterparts, though they usually find it easier to feel busy and useful in retirement because of the domestic chores that are expected of them. One exception is the career woman without a family, who often finds it harder either to plan for or accept retirement.

For the housewife the retirement of a husband often creates problems because while he's been working, their marriage has involved "togetherness" only on evenings, weekends, and vacations. She has developed her own pattern of living while her husband is away at work, and has grown accustomed to making decisions about most household situations which she handled alone. Suddenly, her husband is around the house for hours every day interferring with the routine she has built up. She may become frustrated, upset, and more antagonistic than usual. After years of happy marriage, the two find themselves at odds once their part-time companionship becomes full-time.

Normal physiological changes such as a faster heartbeat or "hot flashes" may break into the wife's consciousness, which she interprets as signs of disease. She often develops a hypochondriacal escape mechanism. She may become a constant visitor to her physician, complaining of aches, pains, and disorders for which no explanation can be found. She is exhibiting symptoms of her middlesence!

The solution evolves when such a woman can find somebody to listen and understand her problem, someone who can help her face it for what it is. Then she can usually sit down with her husband and they can work out their adjustments to his retirement. Such a listener need not be a doctor. Any willing and sympathetic ear will probably be just as effective in bringing the whole thing out into the open.

A New Career at 65?

One suggestion we often come across in reading about the preparation for retirement says, "Every citizen should prepare for retirement by resolving to remain useful in the home and community." That sounds very nice, but what happens when the community will not (or cannot) accept the retirees usefulness? After he's been turned down by three or four organizations or friends to whom he offers his services, a man may find his self-confidence undermined by self-doubts.

One problem is, of course, that the older person, like any outsider, can't know what help others really need. And the person to whom he speaks can't guess at the abilities he's being offered. The best approach is to start volunteering with the organization of your choice before your retirement.

For many older persons, the extra effort before retirement is worthwhile, for they soon find it is better to give than to receive. These are the people for whom the need to do something interesting and helpful was always more important than earning money. Others who may have to be led into such activity for the first time, may find it to be a pleasant, profitable experience, once they're into it. Voluntary, community, religious, or public agencies will advise about several ways of working for fun and service, rather than for pay. Perhaps you need not only activity, but income; you can't afford to work for nothing. The number of people who can successfully start new jobs after sixty-five is small, but that doesn't mean jobs can't be found.

Retirement Drop-Out

Despite our noble pronouncements and well trumpeted efforts, one in six elderly people still live in poverty; one in five occupy an outmoded, substandard living accommodation, and most exist in isolation and loneliness. Innumerable are the *Retirement Drop-Outs,* totally unprepared for retirement.

All too many retired people are institutionalized in nursing facilities solely on the basis of social dislocation, when in fact they need serious personal care and attention rather than nursing or medical care. Most of the needs of the aged retiree are of the personal and self help variety, which can be met by a trained home-visitor rather than an institution. Activity planning for the inactive and bored oldster in his own community would keep many of them out of our institutions.

The resolution of the problems of retired persons resides in large measure with the lack of trained or interested professionals who can counsel them. Specifically, the need calls for expansion and organization of all professionals dealing with the elderly. Concern for those retired, and the many more soon to retire must be translated into immediate planning to solve the elderly American's multiple problems. Through the channels of public information, legislative persuasion, and direct action of professional societies, we must immediately set upon this revolutionary plan, by encouraging recruitment for basic research into the aging process, about which pathetically little is known today. The over 65 population explosion includes many normal old persons, but we have yet to do anything about

all those who will have the chronic illnesses of the elderly, the organic brain disorders, the heart diseases, coronary or strokes. We must constantly be reminded that the many old persons alive today are retired because of medical advances in all specialties except geriatric medicine. Investment in preventive and social community measure would direct and in many cases prevent abandoment, dislocation, crippling, and painful loneliness. Such efforts will not only bring down the skyrocketing costs of unnecessary institutional care, but help to encourage finding some alternative means of preventing isolated and separated housing for the elderly. Segregation on the basis of age or physical status or inactivity alone cannot be the final answer.

Some Answers

Perhaps we should investigate the establishment of combining nursing-homes with nursery-schools, where retired oldsters could benefit from the invigorating presence of children, and the children learn from the accumulated knowledge and wisdom of the elderly. These accommodations could permit retirees to assist teachers of children with many chores. Our aged are the living reservoir of culture and heritage and should be utilized for whatever productivity they can still offer.

The terrible consequences of physical and mental inactivity among the retired can be partially relieved by the expansion of job opportunities for elderly Americans. We need direct drives to end today's flagrant and unlawful discrimination by employers on the basis of age. This is in keeping with all research which shows that, until overt senility has been reached, the older worker is more productive and less accident prone than is his younger co-worker. Certainly they could provide the personal services we all complain have disappeared.

We must work to lower or eliminate real estate taxes for retired Americans. This would allow them to remain in the home of their choice rather than compel them to move to some lower cost facility often supported by public funds. This would also help the elderly supplement their retirement income.

Prevention is the only known cure today for those inactive, lonely, isolated and segregated retirement drop-outs who are doing nothing but waiting to die after retirement both in and out of institutions. Our generation is the first privileged to be alive so many years after retirement. Our present working generation must learn that pre-retirement planning is urgently needed. Far too many of us are only prepared to work for our daily bread or be mere spectators in a busy world, without planning for the magic day when it all ceases.

Conclusion

An overly simplified screening test for preparedness for retirement is to ask a worker what he does in his so-called spare time. What does he do on his days off? On his vacation? Answers to these questions may quickly reveal what will be done when working days are over. All too many of us have yet to discover that what we call 'work' need not result only in financial remuneration. Self-gratification, self-stimulus, personal pleasure and a feeling of accomplishment are also valuable rewards. Of course this presupposes in all reality, that the basic necessities are present —which in itself also requires pre-retirement planning.

We need *Islands of Care,* in communities that don't care. In-town Retirement Villages can become community oriented service centers that will incorporate the lives of retired persons in the general community with special and selective programs for the residents of the village. The retirees can have their special city-club.

We must impress our concern and hope upon the youth of our society, so they will have the vision and the will to join us in seeking answers before the problems become unsolvable. We need one master comprehensive policy, not crash programs. If the Retirement City-Village concept is not satisfactory at least let someone propose an adequate alternative.

As for today's elderly, they need our help—government, private enterprise, and non-profit. They have earned it and it is our duty to supply it. What about you? Have you made plans as to where, and to what you will retire? Are your plans realizable? Are you suffering from middlesence?

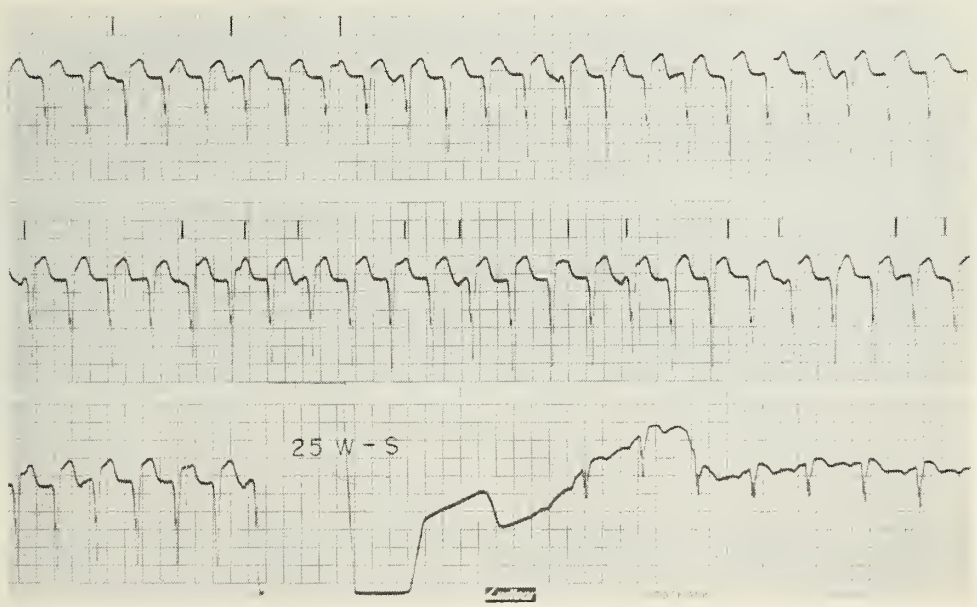
We need action now if we are to be ready for your retirement. In about 25 years the median age of our general population will increase from today's 28 years to 36 years, and in the same period our over 65 population will double from 10% to 20%.

The health and social needs of retirees can be met without total banishment from society. The Village concept would permit many and varied facilities, as well as a pool for expensive equipment and specialized personnel. The concentration of voluntary and official agencies, outpatient and inpatient facilities will improve accessibility and communication among the different facilities and personnel, while still in close and direct contact with the general community. In addition to the concentrated grouping, satellite facilities can also be developed close to those needing similar services in the general community. ◄

ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A fifty-six year old man had severe angina for two years. He was incapacitated by his chest pain and so he was referred for coronary arteriography. Subsequently, he underwent open-heart surgery and aorto-coronary bypass. For over a year he did well, even returning to work. He came to the emergency service with a history of palpitations, and the top two panels are the ECG rhythm strips that were taken. His blood pressure was 100/70.



Questions:

1. The ECG shows:
- A. Atrioventricular dissociation.
- B. ST segment elevation.
- C. Atrial fibrillation with a rapid ventricular response.
- D. Atrial flutter with block.
- E. Ventricular tachycardia.

2. Treatment would include:
- A. Direct current cardioversion.
- B. Procainamide.
- C. Digitalis.
- D. Pacemaker.
- E. Propranolol.

(Continued on page 482)



Foreign Medical Graduates

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

By Kong Meng Tan, M.D. and Michael Hughey, M.D.

The subject of foreign medical graduates is in vogue these days. Call it what you will, the situation is being carefully scrutinized by a plethora of organizations. The list reads like the aristocracy of organized medicine, *viz.*, the American Medical Association, The Association of American Medical Colleges, the American Hospital Association, the Coordinating Council on Medical Education, the Educational Commission on Foreign Medical Graduates, the Institute of Medicine of the National Academy of Sciences, the National Board of Medical Examiners, as well as many specialty societies, the surgeons and the psychiatrists being the more prominent in this field. So all encompassing is this interest that even Congressional leaders as well as federal government departments—State, Labor, Justice, and Health Education and Welfare—are paying close attention to the effects of foreign medical graduates upon the health care system of this country.

Thus far, several reports offering short and long range solutions have surfaced. Invariably, they reflect the interests of the organization sponsoring the report. The literature has been replete with articles and editorials, pro and con. The issues are centered on two premises, (1) the numbers of foreign medical graduates migrating to and settling in the United States are getting much too large, and (2) how competent are they? The rest of the issues appear to be incidental and of peripheral concern to these two central points.

The AAMC is concerned with the fact that foreign graduates occupy over 35% of the available positions in graduate medical education and that there are insufficient positions, in domestic medical schools for the large pool of qualified applicants that deluge admissions committees every year, thus forcing large numbers of Americans to study abroad. The American students then return to become part of the "problem." This is a valid concern, no doubt. Yet, it is questionable whether the AAMC's recommendation to reduce the number of internship and residency slots, available to foreign medical graduates to a minimal number would solve the problem. Such a solution might even exacerbate the situation as the number of returning graduates who are U.S. citizens will probably exceed the number of openings available. Their concern, moreover, that U.S. medical schools should assume all authority for certification of graduate programs for foreign trained physicians wishing to enter the health care field is bound to alarm many community hospitals. The AAMC has unfortunately allowed its eagerness to obtain more money for more schools, to color many aspects of its report on FMG's. As a consequence, the FMG frequently ends up playing the scapegoat's role.

The NBME (National Board of Medical Examiners) is worried about competency. Thus, like many other groups, it proposes a uniform examination to be applied to FMG's as well as USMG's. This is the only recommendation that housestaff have accepted in principle from the now famous GAP report. We believe it is necessary to dismiss the selective discrimination against foreign graduates based solely on the results of different examinations applied to FMG's and USMG's.

Competency of foreign medical graduates is anecdotal and often based on questionable statistics which are elusive in character, rapidly changing and misleading. They can be easily manipulated to back almost any position. They are cold and distinct in impact but give no hint of the pertinency of the factors involved. Two excellent articles recently appeared in the *New England Journal of Medicine* and *Scientific American* that question the long accepted use of certain statistics to confer incompetency of foreign-trained physicians, whether foreign born or native Americans.

It is even more bewildering and disheartening to learn, in a private conversation, that a leading staff aide who wrote manpower legislation for his Congressional mentor was down on foreign grad-



New Officers and Trustees

Highlights of Convention '75

ummary of House Actions

Illinois State Medical Society
1975-76 Officers
and
Board of Trustees

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House of Delegates

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VICE-SPEAKER	Herman Wing, 400 E. Randolph, Chicago 60601

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Convention Highlights '75

The 135th Annual Meeting of the Illinois State Medical Society and the Midwest Clinical Conference was attended by over 3200 physicians, Auxiliary members, Medical Assistants, medical students and visitors. More than half of those attending were Illinois physicians who attended scientific lectures, participated in the ISMS House of Delegates, and listened to presentations by government persons and others, especially as they related to medicine in Illinois.

The Committee on Credentials recorded attendance as follows at the 1975 assembly of the ISMS House of Delegates:

	Officers & Trustees	Speaker Vice Speaker	Downstate	Cook County	SAMA	Housestaff
First Session 49 countries	23	2	70	68	1	1
Second Session 56 counties	23	2	79	55	1	1
Third Session 51 counties	23	2	81	46	1	1

The first session of the House of Delegates convened at 3:00 p.m. Wednesday, April 2. After the report of the Credentials Committee, Dr. Jacob E. Reisch, ISMS Secretary-Treasurer, conducted a memorial service in honor of the 166 physicians of ISMS deceased since April, 1974.

Spring Blizzard

Due to a snowfall of over a foot on the first night of the 135th Annual Convention, many physicians and their wives as well as a few speakers were stranded on the road and in hotels and airports from Indianapolis, Indiana to Chicago. The program on "Medical Management of Alcoholism" was cancelled because the three speakers were unable to get into Chicago. This program was to be rescheduled later in the year. Casper Weinberger, HEW Secretary, also was unable to make it to McCormick Inn for his scheduled appearance at one of the Conference Feature Hours.

AMA-ERF Contributions Total $131,331 to Illinois Schools



Dr. Ingalls presenting check to Dr. Falk

Presentation of the AMA-ERF check was preceeded by an indication that Illinois physicians have contributed over $3 million to the foundation since the program began.

ISMS President J. M. Ingalls presented a check for $131,331.24 to Marshall Falk, M.D., Dean of Chicago Medical School, who was representing the Illinois Council of Medical School Deans.

The American Medical Association-Education and Research Foundation distributes funds to medical schools throughout the United States. Twelve Illinois medical schools received checks this year. These funds were distributed as follows:

Rush Medical College	$11,408.60
Pritzker School of Medicine of the University of Chicago	12,089.32
Northwestern University Medical School	28,092.52
University of Illinois College of Medical Foundation	13,914.02
Chicago Medical School	17,598.73
Loyola University Stritch School of Medicine	19,682.51
Southern Illinois University School of Medicine (SIU Foundation)	8,601.35
Southern Illinois University Foundation—Carbondale	840.90
University of Illinois Foundation, A. Lincoln Campus—Springfield	12,257.50
University of Illinois Foundation—Champaign	781.00
Rockford School of Medicine	2,065.82
Peoria School of Medicine	3,998.97



Mrs. Johnson

Medical Assistants Report

Mrs. Vivian Johnson, president of the American Association of Medical Assistants—Illinois Society, presented an annual report to those assembled. She emphasized the accomplishments of the eleven educational sessions held throughout Illinois. These workshops, focused on improving the efficiency and productivity of Medical Assistants, were made possible through sponsorship of ISMS. Mrs. Johnson cited continued growth of the society the past year and urged continued interest of ISMS in the Association.



Dr. Callahan and Dr. Sheehan

Hamilton Teaching Award

The 1975 Edwin S. Hamilton Teaching Award was presented to John F. Sheehan, M.D. Dr. Sheehan received a plaque and honorarium from George B. Callahan, M.D., Waukegan, Trustee to the Interstate Postgraduate Medical Association.

Dr. Sheehan was Dean of the Loyola University-Stritch School of Medicine from 1951 through October, 1968. A former student of Dr. Sheehan's who spoke at the presentation ceremony stated, "I thought he was fair; I remember more pathology than any other subject; and he taught it." Dr. Sheehan has been active in academic medicine throughout his career. He was on the Loyola University faculty from 1937, when he was an Associate in the Department of Pathology, until his retirement from the post of dean. Now a resident of Arizona, Dr. Sheehan was a member of ISMS, the Chicago Medical Society, and many other professional societies.

This was the tenth year for this award in recognition of Edwin S. Hamilton, M.D., Kankakee, a former ISMS president and active participant in IPMA. The ISMS Council on Education and Manpower selects the annual recipient.

IMPAC Report Calls for Participation



Dr. Tworoger

Fred A. Tworoger, M.D., Chairman of the Illinois Medical Political Action Committee, in his report to the House of Delegates, reflected upon the political upheaval that has shaken the American public this past year. This has increased the gap between the people and the politicians. However, "with such medical issues as National Health Insurance, malpractice medical discipline reform, and hospital rate review in the spotlight, medicine cannot afford to be apathetic," Dr. Tworoger stated. He indicated that the very "basics" of the profession are at stake.

Dr. Tworoger further emphasized the vital necessity of the medical-to-legislators link if the profession is to survive. Physicians must take the time, the money, and the effort to tell their story.

Dr. Tworoger encouraged all ISMS members to join IMPAC. Last year 41% of ISMS member-physicians remitted the minimal $25.00 fee for IMPAC-AMPAC membership. Only 56 members contributed $99.00 to become sustaining members. Auxiliary PAC members increased dramatically from 50 members in 1973 to 3899 at the end of 1974.

IMPAC-AMPAC Workshop



Congressman Crane

A complimentary luncheon and workshop sponsored by IMPAC-AMPAC was held during the ISMS annual meeting at McCormick Place. Lee Ann Elliott, Associate Executive Director of AMPAC, presented four awards to Fred Tworoger, M.D., IMPAC Chairman. IMPAC won national first place awards in membership and most woman members. The other two awards were second places for amount of total contributions and the all events category.

In his keynote address Congressman Philip M. Crane, a member of the Health Subcommittee of the House Ways and Means Committee, indicated he does not believe that NHI is as much of an emergency in the eyes of the people as those in Congress who are pushing the bill believe. He stated that the bill before Congress is not only inequitable in its coverage, but that it would create even more chaos if it were enacted.

Mr. Crane urged everyone present to let the physician's view be known. Mr. Crane emphasized that NHI is "not inevitable" but it could become a self-fulfilling prophecy unless physicians speak out. Those present were asked to write their Congressman, to see their representative when in Washington, to take advantage of any chance to proselytize about NHI, and to exert political pressure by whatever means is necessary.

In conclusion Mr. Crane stated NHI is a violation of medical ethics. Physicians must lead this battle, not only to preserve individual freedom but also the fate of liberty in the United States. "The history of liberty is a limitation of governmental power," Crane quoted from Woodrow Wilson, and that is what this battle is about.

Foundation for Medical Care Report

The annual report of the Illinois Foundation for Medical Care was presented to the House of Delegates by Allan L. Goslin, M.D., President of IFMC. The Foundation has become increasingly involved in establishing criteria and guidelines for physician evaluation and review. Since January, 1975, IFMC has developed a program to assist hospital medical staffs, review committees, and administration in complying with new federal review requirements. This program, entitled Physician Evaluation Educational Review System (PEERS) will serve as a mechanism for review committees to evaluate physician care against local criteria, as well as regional norms of practice.

IFMC also has developed a document of Minimum Standards for Health Foundation Insurance Programs which is currently under review, and is working on the development of Individual Practice Associations (IPA), as well as other physician-sponsored alternatives to closed-panel HMO's.

Auxiliary Reports Successful Year

Mrs. Thomas R. Glatter, President of the Auxiliary to the Illinois State Medical Society, reported to the ISMS House of Delegates that the past year had been very successful in developing leadership and communication among county Auxiliaries. Miniworkshops on leadership held throughout the state were attended by over 300 doctor's wives.



Mrs. Glatter

The Auxiliary also sponsored a walk-in for the immunization of children, which was a great service to the community as well as a help to the Illinois Department of Public Health.

There was an increase in membership in the Auxiliary, as well as a tremendous increase of WA members in IMPAC. Mrs. Glatter emphasized the need for physicians' wives to be more aware of legislation affecting medicine and take pride in their contribution to the future of medicine. She invited physicians to purchase their spouses' memberships in the Woman's Auxiliary and IMPAC.

In conclusion, Mrs. Glatter and the WA Board of Directors extended thanks to ISMS and the Advisory Committee to the Auxiliary.

Report of the Executive Administrator

The Illinois State Medical Society holds a strong and influential position in medical matters in this state, said Roger N. White, ISMS Executive Administrator. However, he indicated the society must move forward in support of a viable system of private medicine. To accomplish this task, Mr. White told the House there has to be an effort made to involve all the members of the society. Not only must the members understand the goals for which the Society is working, but they also must recognize the society's capabilities to help physicians maintain the private, independent practice of medicine.

The fates of HMO programs and the PSRO were cited as examples of what happens to organizations without the support of the people for whom they are established, especially when the funding is lacking. The same lot may await the National Planning and Resources Development Act. "This does not mean physicians should sit back and relax," said Mr. White, "now is the time to act. With the political and economic backing of ISMS, physicians can not only build a better way of doing what the government wants done, but they can also preserve 'free choice' medicine."

Medical Journalism Awards

The 1975 Medical Journalism Awards were presented before the House of Delegates for the first time this year. Alan Taylor, M.D., Vice-Chairman of the ISMS Council on Public Relations, moderated this event while ISMS President J. M. Ingalls presented the awards, a certificate and $300.00. The Medical Journalism Awards Program was established in 1964 to honor members of the newspaper, radio, and television media for their outstanding achievements in promoting a better public understanding of medicine and health in Illinois. The winners of these awards for 1974 stories were:



WKRS, Waukegan—"Heart Attack: Surviving the First Hours," written, produced and moderated by Larry Leonard.

WIND, Chicago—"Rape: A Crime, But a Medical Problem, Too," written and produced by Christine Harris and Ann Williams.

The Alton Telegraph, Alton—"The Battered Child," a four-part series written by Ande Yakstis and Pat Plarski.

The Chicago Daily News, Chicago—"Cafe Coronary," written by Art Snider, Daily News Science Editor.

WTVP, Peoria—"Peoria's Lifesaver," produced by Janet Porter and David Dzurak.

WBBM, Chicago—"Reconstructive Surgery," produced by Terry Fern and narrated by Bob Faw.

Introduction of AMA Delegation

Edward A. Piszczek, M.D., Chairman of the ISMS Delegation to the American Medical Association, introduced the AMA delegates and alternates. Current delegates are: Drs. Carl E. Clark, Alfred J. Faber, Jack L. Gibbs, Theodore Grevas, H. Close Hesseltine, Maurice M. Hoeltgen, William M. Lees, Morgan M. Meyer, Philip G. Thomsen, and Charles K. Wells.

Alternate delegates are: Drs. Herschel Brown, Allison Burdick, Jr., J. M. Ingalls, Fredric Lake, Eugene T. Leonard, Joseph R. O'Donnell, John J. Ring, George Shropshear, Glen Tomlinson, Fred A. Tworoger, and Theodore R. Van Dellen.

Professional Liability Program

A program entitled "Medical Liability and the Doctor Defendant" was presented April 3, 1975, at McCormick Place, in cooperation with the Chicago Academy of Law and Medicine (CALM). The program chairman Herman Wing, M.D., LI.B., introduced four speakers who discussed various sides of the medical liability problem and then held a panel discussion answering questions from the audience.

John Stimpson, Vice President of Johnson and Higgins, pointed out the insurance companies historically have been inaccurate in predicting the cost of claims for medical liability protection. But the insurance industry is collecting data and statistics so that more accurate and prompt evaluations can be made and free enterprise can be preserved.

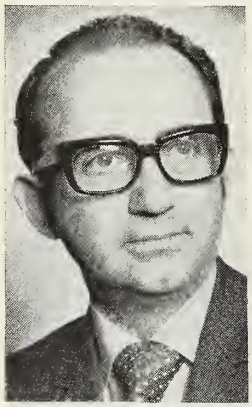
John D. Hayes, J.D., told the physicians present that a patient's expectations of the outcome of treatment are not always realistic. Therefore it is the doctor's responsibility to inquire into the patient's attitude, said Mr. Hayes, and to inform him in advance of possible good and bad results of treatment. Otherwise, the doctor is leaving himself open for litigation. Mr. Hayes added that from the doctor's viewpoint "malpractice" is gross negligence, but in the patient's eyes it is anything less than the best possible or a 100% recovery.

Speaking from the defendant physician's point of view was Mr. John White, J.D. Mr. White's first recommendation to the physician, after he receives a referral, was to "keep eyes and ears open but mouth shut." It is unguarded comments which cause the defendant the most trouble. The physician always should contact his lawyer and insurance broker when a suit is in the offing. Mr. White also recommended that the doctor be available to defense attorneys throughout the period until settlement.

Present to explain the "Anatomy of a Malpractice Claim" was Harold Jacobson, J.D. Mr. Jacobson discussed the various steps in completing a claim and also identified some of the kinds of testimony in such cases.

In conclusion Dr. Wing and Leonard Klafta, M.D., Chairman of the ISMS Medical-Legal Council, summed up with suggestions about what might be done to alleviate the increasing number of malpractice claims.

Public Affairs Breakfast



Dr. Sammons

AMA Executive Vice-President James H. Sammons, M.D., spoke on the AMA's National Health Insurance Proposals at the Public Affairs Breakfast. Dr. Sammons informed the physicians and their wives that he did not see the passing of NHI in the immediate future (the year 1975). However, he did indicate that national health care financing probably will be instituted some day. Therefore physicians were urged to get involved and act responsibly to determine the course of such legislation. Dr. Sammons stated that doctors must work to develop their own legislation on health care financing so that if NHI is passed, it will be in an acceptable form.

Dr. Sammons concluded with remarks about another bill before Congress. This bill dealt with health manpower and the training of professionals. Under the proposal a committee would determine where resident physicians would train.

The Gray Panthers Pay a Visit to Physicians

A special reference committee, chaired by Jack L. Gibbs, M.D., met in open and executive session on April 3, 1975, to consider a position paper presented by the Chicago Gray Panthers, a group of senior citizens involved in improving the health care and quality of life for the aged and aging.

During this unexpected visit at the ISMS annual meeting, the Gray Panthers called upon ISMS to: (1) initiate the development of accreditation standards relating to gerontology and geriatrics courses by the LCME; (2) initiate the reactivation of the AMA Committee on Aging and Community Health, charged with action on home health care issues; and (3) resolve to admit a consumer advocate selected by the Gray Panthers to the ISMS House of Delegates.

Conference Feature Hour



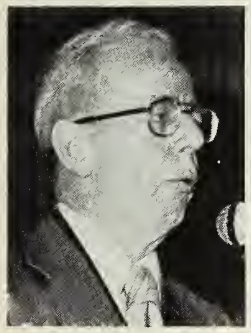
Rep. Rostenkowski

Representative Daniel Rostenkowski, Chairman of the Health Subcommittee of the House Ways and Means Committee, spoke on National Health Insurance and the 94th Congress at a Conference Feature Hour. The Subcommittee was to begin consideration of NHI even though President Ford did not consider it a priority issue. Congressman Rostenkowski indicated it would be at least a year before any program could be implemented once passed, thus the need for immediate action.

Congressman Rostenkowski did not endorse any specific plan for NHI. There are two basic principles, however, which he felt must be embodied in effective NHI legislation. First, the plan must be realistic and workable in practice and theory. Second, such legislation must increase the effectiveness of the health care profession, maximizing the amount of time doctors can spend with their patients.

In conclusion, Congressman Rostenkowski announced an in-depth study of the problem. He will seek information through an advisory panel during the months ahead, so that a program can be developed which "will hopefully be the basis for legislation that will benefit all Americans for generations to come."

President Lake Laments Unfulfilled Mission



Dr. Lake

During the second session of the ISMS House of Delegates, Fredric D. Lake, M.D., retiring ISMS President, lamented that the mission he had outlined in his inaugural address one year ago was unfulfilled and that the fate of the medical profession was growing grimmer by the day.

He spoke first of internal problems, particularly the lack of communication on the professional level. He urged physicians to forget petty jealousies and get on with their work!

Aside from internal affairs, Dr. Lake thought it was ironic that as this country approaches its 200 year celebration of Independence, physicians have cause to mourn because their professional freedom is being usurped by meddelsome government bureaucrats. "What sharpens the sadness as I contemplate our plight," said Dr. Lake, "is that the demise of our professional independence has been aided by the vast indifference of most of our colleagues. . . ."

Dr. Lake did report progress, however, both in cementing relationships with the various specialty societies and in seeking greater involvement of academia in organized medicine.

In closing, Dr. Lake thanked Dr. Ingalls for his support and assistance and Dr. Bordenave for his effective direction of the board. He also expressed his great pleasure at having been able to serve the society.



Mrs. Sweeney, wife of Past-President Leo P. A. Sweeney in back and Past-President Arkell Vaughn

Fifty Year Club Honors 91

The annual luncheon of the Fifty Year Club honored 91 new members of this elite group. Harold A. Sofield, M.D., Chairman of the Fifty Year Club, said this was the largest crowd of physicians, wives, and children ever present at the luncheon.

Guest speakers at the luncheon were Mary and Charles Hare, English tennis champions now living in the United States. Mary Hare spoke about being a tennis veteran. Charles Hare lectured on the "Investment Outlook for Senior Citizens."

After the speeches, Dr. Sofield presented plaques and pins to the freshman members of the Fifty Year Club. These physicians are ISMS members who began the practice of medicine fifty years ago, after graduation in 1925.



Freshman Fifty-Year Club member Patrick A. Cusack, M.D., and his sons Wm. Cusack, D.D.S., Michael Cusack, M.D., James Cusack, M.D. and Thomas Cusack, M.D.

AMA President Addresses House



Dr. Todd

Malcolm Todd, M.D., President of the American Medical Association, was a guest speaker at the closing session of the House of Delegates. He praised the Illinois State Medical Society highly for its leadership in the AMA, as well as for respect commanded from legislators in Illinois.

President Todd emphasized the mutual need of physicians and the organized medical society for each other. The AMA officer urged those present to encourage young doctors, students, and medical academicians to join the AMA, so a strong and unified voice from physicians can be heard at the state and national level. "When 11% of the legislation in Congress deals with medicine, how can action be taken if legislators are not informed and influenced," asked Dr. Todd?

Dr. Todd briefly discussed the AMA's policy on several national issues, including the Maximum Allowable Cost regulations, medical liability, and NHI. The AMA is working on legislation and other programs to alleviate all of these problems, as well as bringing suit to protect the public well-being.

A Practical Look at Medical Direction in Long-Term Care Facilities

On April 1st and 2nd, 1975, ISMS' Committee on Aging brought together physicians, nursing home administrators and owners, and nurses to discuss the role of a medical director in a skilled nursing home. New federal regulations mandated that all skilled nursing facilities employ a physician as medical director, to coordinate patient care and provide medical input into the everyday life of a skilled home.

Speakers on the first day touched upon the roles, responsibilities and relationships of the medical director in relation to the nurses, administrator, owner, patient, and attending physicians. Small group workshops were used to permit the participants to exchange views on various hypothetical situations and problems which arise in the nursing home.

The second day was devoted to examining specific questions about the regulations. Presentations were given on "Who Will Pay the Bill?; The Medical Director and Utilization Review; Alternative Methods of Medical Direction; and The Medical Director's Exposure to Liability."

An evening dinner caucus brought together representatives of medical societies, medical schools, state government, and the state legislature to discuss how Illinois can deal with the lack of medical directors and the role of the professional, educational, and governmental bodies in improving the situation.

The conference, made possible by an HEW contract with the AMA, brought to the surface a great number of inconsistencies, ambiguities, frustrations, and hopes about the future of medical direction in nursing facilities, and those who are to be responsible for it.

Dr. J. M. Ingalls Inaugurated ISMS President



Dr. Ingalls sworn in by Dr. Lake

In his inaugural speech as ISMS President, J. M. Ingalls, M.D., expressed concern about continuing internal strife, which keeps ISMS from getting on with the activities it should be about. He announced appointment of a President's Committee to study the problem of communication between the Third District delegation and the Downstate delegation, so that emotional misunderstandings can be eliminated. The men appointed to this committee were Eugene P. Johnson, M.D., David S. Fox, M.D., Alfred J. Faber, M.D., and Mather Pfeiffenberger, M.D.

Dr. Ingalls indicated the second area of greatest concern to him was reinforcement of the physician's interest in his patients. He further stated that doctor's experience and expertise must regain preeminence in social planning, and that those non-medical professionals who would interfere with medical care must show their qualification to do so. Doctors must become advocates for patient welfare, as well as develop increased personal contact with patients.

Ideals to which Dr. Ingalls committed himself for the coming year as ISMS President were:

- involvement of more physicians
- elimination of control in ISMS by any one faction
- reorganization of the society, if necessary, to preserve it as a forum for physician representation
- return to consideration of doctors' experience and knowledge as the criteria for decisions about medical care.

New Officers and Trustees Elected

New officers of the Illinois State Medical Society were elected in the final session of the House of Delegates. Elected for 1975-1976 terms were:

President-Elect: Joseph Skom, M.D., Chicago
1st Vice-President: Eli L. Borkon, M.D., Carbondale
2nd Vice-President: Warren Young, M.D., Crete
Secretary-Treasurer: Jacob E. Reisch, M.D., Springfield
Speaker of the House: James A. McDonald, M.D., Geneva
Vice Speaker of the House: Herman Wing, M.D., Chicago

Trustees elected for three year terms were:

Third District:	Eugene T. Hoban, M.D., Oak Park Samuel Cloninger, M.D., Skokie Henrietta Herbolsheimer, M.D., Chicago
Sixth District:	Robert R. Hartman, M.D., Jacksonville
Ninth District:	Warren D. Tuttle, M.D., Harrisburg
Tenth District:	Julian W. Buser, M.D., Belleville

Also, Alfred Clementi, M.D., Arlington Heights, to fill unexpired term of David Fox, M.D.

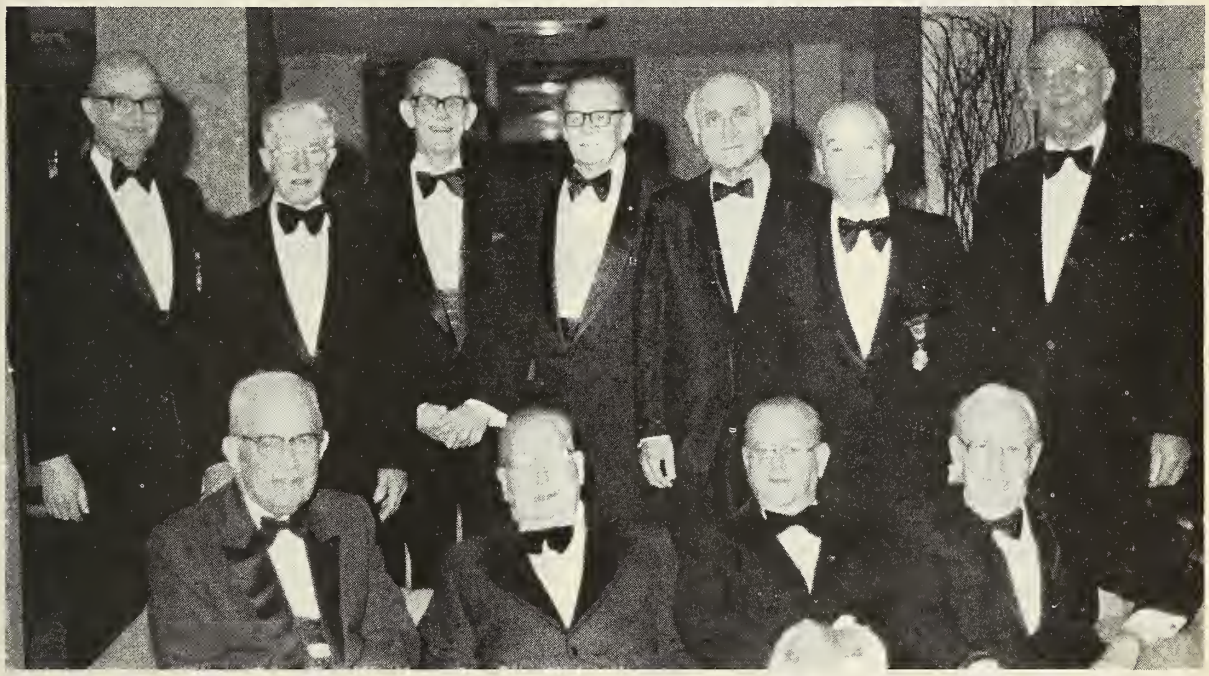
The House created a new trustee district, 1A, and authorized another position from the Third District. Elections to these positions will be accomplished at a later date.

AMA Delegation Elections

One of the final actions of the 1975 ISMS House of Delegates was to elect members of the delegation to the American Medical Association. Elected to begin terms April 5, 1975 were: John J. Ring, M.D., new delegate position; Lawrence Hirsch, new alternate delegate position; Fred A. Tworoger, M.D., delegate vacancy; Robert P. Johnson, M.D., and George T. Wilkins, M.D., alternate delegate vacancies.

Other elected members of the delegation to the AMA who will take office January 1, 1976, and serve until December 31, 1977, were: delegates—Jack L. Gibbs, M.D.; Theodore Grevas, M.D.; Morgan M. Meyer, M.D.; Edward A. Piszczek, M.D.; and Howard Burkhead, M.D. Alternate delegates elected: Herschel Browns, M.D., Allison Burdick, Jr., M.D., George Shropshear, M.D., David Fox, M.D., J. M. Ingalls, M.D., Joseph R. O'Donnell, M.D., and Glen Tomlinson, M.D.

Past Presidents Gather for Gourmet Dinner



On the eve of the ISMS annual meeting, 10 past presidents gathered for a gourmet dinner at McCormick Inn. The past presidents paid tribute to Willard C. Scrivner, M.D., Immediate Past President. Jacob E. Reisch, M.D., ISMS Secretary-Treasurer, served as host for the affair.

Present at the dinner were: back row (left to right)—Charles J. Jannings, III, M.D., J. Ernest Breed, M.D., Jacob E. Reisch, M.D., Newton DuPuy, M.D., Caesar Portes, M.D., Willard C. Scrivner, M.D., and Edward A. Piszczek, M.D.

Front row (left to right)—E. P. Coleman, M.D., Arkell M. Vaughn, M.D., Burtis E. Montgomery, M.D., and Leo P. A. Sweeney, M.D.

Reference Committees Prepare Reports for House Approach

The second and third sessions of the 1975 ISMS House of Delegates heard reports of eight reference committees which met opening night and into the early morning hours preparing reports for the House. Each committee listened to comments on assigned resolutions and reports, and then met in executive session to draft the report.

Serving as Chairman of reference committees were:

Reference Committee A—Allen C. Hrejsa, M.D.
Reference Committee B—M. P. Meisenheimer, M.D.
Reference Committee C—Jack L. Gibbs, M.D.
Reference Committee D—Karl Deterding, M.D.
Reference Committee E—Guy Pandola, M.D.
Reference Committee F—Alfred J. Faber, M.D.
Reference Committee G—M. K. Kaufman, M.D.
Reference Committee H—Jack L. Gibbs, M.D.

Summary of Actions of the 1975 House of Delegates

I. AMENDMENTS TO CONSTITUTION AND BYLAWS

The House amended the bylaws to:

A. Eliminate the citizenship requirement for membership in ISMS.
B. Name the immediate past president of ISMS, rather than the president-elect, as Chairman of of the Advisory Committee to the Woman's Auxiliary.
C. Clarify procedures for filing and appealing ethical relations cases.
D. Specify that the immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.
E. Establish a Planning and Priorities Committee, headed by the president-elect, to review ongoing programs and develop plans for the future.
F. Allow all enrolled medical students to join ISMS rather than wait until their second year of school.
G. Permit medical student members to elect their own delegate and alternate delegate to ISMS.
H. Limit the tenure of trustees to three consecutive three-year terms.

Approved for presentation to the 1976 House of Delegates a constitutional amendment which would eliminate the requirement for "general scientific meetings" to be held in conjunction with the ISMS annual convention.

The House rejected proposals to: (1) Require caucuses to present two nominations for each major office; (2) Deny officers and trustees voting privileges in the House of Delegates; (3) Change the voting power in the House by lowering apportionment from the current one delegate for every 75 members to one for every 65; and (4) Require the Board of Trustees to review the chartering of component societies with a view toward grouping those with small memberships.

II. COMMITTEE A (Reports of Officers and Administration)

To ensure effective liaison between the Board of Trustees and the Illinois Delegation to the AMA, the House ordered an amendment to the bylaws which would add the Delegation Chairman as an ex officio member of the ISMS Board of Trustees and its Executive Committee without vote.

To improve communications between ISMS and its component societies, the House directed the Society to conduct a Leadership Conference for officers of county medical societies and branches of the Chicago Medical Society.

A proposal to have semi-annual meetings of the House of Delegates was referred to the Board of Trustees and its Finance Committee for study and recommendations to be made at the 1976 annual meeting.

Through an emergency resolution, the House established a new trustee district (1-A) comprising the counties of Boone, Carroll, DeKalb, JoDaviess, Lee, Ogle, Stephenson, Whiteside and Winnebago. Authorization is for a two-year trial period, during which time District 1-A will have representation on the Board of Trustees. The Third District also will be entitled to an additional trustee during this period. In a related action, the House ordered ongoing review of redistricting recommendations by reappointing the 1974-75 ad hoc committee on redistricting.

III. COMMITTEE B (Economics, Peer Review, Social & Medical Services)

Considered to be medicine's most pressing problem, professional liability insurance coverage was the sub-

ject of several actions. The House:

A. Adopted the following policy statement:

> "We continue to endorse the concept of effective peer review by a committee of physicians appointed by the ISMS to review all questions of professional liability insurance coverage, including both new applications and cancellations of existing policies.
>
> "We reaffirm the policy that a physician has a right to personally appear before the appropriate peer review committee in all questions of obtaining professional liability insurance coverage and/or in the question of cancellation.
>
> "ISMS will monitor the current assurance from the ISMS carrier that if the committee finds in favor of the physician, the insurance company will provide full coverage.
>
> "The membership will be given frequent and timely progress reports on the problem."

B. Received information that the Board of Trustees is implementing an eight-point legislative program to ensure that patients, physicians and lawyers are treated equitably while helping stem the rising costs of health care and strengthen the medical profession.

C. Opposed for the present time the "no fault" concept for professional liability.

D. Authorized the Board of Trustees to establish a mechanism to raise a medical legal fund, to be used in a carefully selected case in which a physician practicing in Illinois has been subjected to a frivolous suit and seeks redress from the patient and/or patient's lawyer who have made apparent malicious abuse of the due process of law. The Board was authorized to levy a mandatory assessment on each member a sum—not to exceed $10—as may be necessary to support this program.

E. Directed the Board of Trustees to rescind its position statement dated April 5, 1974 which proclaimed: "It is the responsibility of the hospital governing board to assure itself that a physician's license to practice medicine and his professional liability insurance are current and in force. This assurance should be provided by the medical staff. . . ."

In the area of medical service and physician reimbursement, the House:

A. Adopted a policy that "if under any governmental health insurance program non-medical services are to be reimbursed, a separate category for such reimbursement should be established, with separate payment, and be optional to the insured." The AMA will be requested to take similar action and seek repeal or modification of PL 93-363.

B. Adopted a policy advocating that psychiatric illness in all its forms be given comparable coverage as for any other medical illness, for active inpatient or outpatient medical treatment under any current or proposed governmental insurance programs. AMA will be requested to seek an end to such discrimination.

The House also:

A. Refused to rescind its ban on the use of federal funds by ISMS or the Illinois Foundation for Medical Care in implementing ISMS-approved activities.

B. Adopted the policy that "Unless physicians appointed to the boards and committees of other organizations, such as local Comprehensive Health Planning 'b' agencies, are nominated by their local county medical society, such physicians shall not be considered 'representative' of the medical community."

C. Encourage development of local peer review plans for appropriate review of utilization of hospital emergency rooms.

D. Offered to provide utilization review and peer review to the Veterans Administration for hospitals in Illinois. The AMA will be asked to promote the concept of identical standards of review for all hospitals throughout the country.

IV. COMMITTEE C (Education and Manpower)

The House ordered continued funding of the Illinois Council on Continuing Medical Education by allocating half ($10) of each member's 1976 AMA-ERF contribution. It also directed the Board of Trustees to take appropriate steps to recruit more hospitals for the Medical Education and Community Orientation program (MECO) so that additional students can be exposed to communities where they may eventually wish to practice medicine.

V. COMMITTEE D (Environmental, Community and Mental Health)

The House endorsed the following definition of psychosurgery:

> "Psychosurgery refers to those surgical operations which irreversably destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms, and chronic pain syndromes, nor does it include non-surgical electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation, and reasoned consent."

It also reaffirmed its position that "mental health benefits be made a mandatory option for inclusion in all health policies written in this state" and urged all component society members to contact their legislators in support of such legislation if such is introduced in the legislature this year.

The House directed ISMS to request the American Medical Association to: (1) Refrain from giving preferential support to Community Mental Health Center extension legislation to permit psychiatric patients to maintain a free choice of physician; and (2) Reaffirm that any legislation authorizing non-physicians to engage in the diagnosis or independent treatment of mental, emotional or nervous disorders is in conflict with the public interest.

VI. COMMITTEE E (Finances, Budgets and Publications)

The House took the following actions on matters related to PSRO:

A. Rejected a resolution that would have ISMS render assistance to PSRO organizations in the state and to cease its support of such organizations outside the federal system. It was pointed out that the matter had been thoroughly reviewed and acted upon at the November, 1974, special session of the House of Delegates.

B. Directed that members who have not paid the Special ($25) Assessment be notified by letter that failure to do so is jeopardizing their continued membership in the Society, with loss of all rights and benefits. The attention of the House was called to previous action ordering "that any assessment remaining unpaid at the close of the current (1974) fiscal year be levied as a part of the required membership dues for 1975."

C. Directed the Board of Trustees to take an active role in uncovering any violation of the doctor-patient confidential relationship by PSRO officials and personnel and to take whatever steps are necessary to eliminate the breach of confidence.

In a related action, the House adopted the policy, "That third parties, including government personnel, insurance carriers, review organizations and hospital personnel be informed and educated to recognize that prognosis and length of treatment must always be individualized to the patient, rather than to the diagnosis."

In recognition of the increasing burden placed upon its officers, the House directed that the incoming President and Chairman of the Board of Trustees be compensated with an annual stipend of $10,000, and the President-Elect $3,000, in lieu of current per diems. The House also approved continued funding of liaison activities with medical students, interns and residents through a dollar per member assessment.

VII. COMMITTEE F (Governmental Affairs and Medical-Legal)

The House adopted the following policies on legislative and medical-legal matters:

A. "The package insert labeling of pharmaceutical preparations (should) be identified only as a guide in the clinical application of the product, and not as an absolute standard limiting the practice of medicine." (The AMA will be requested to adopt a similar policy, apprise the U.S. Dept. of HEW, and encourage the Food and Drug Administration to clarify the purpose of the package insert.)

B. "Acupuncture is a surgical procedure and should be limited to physicians licensed to practice medicine in all its branches . . . and dentists." (This policy reaffirms the previous ISMS position on acupuncture.)

C. "ISMS expresses its continued concern regarding the legalization of marihuana and reiterates its opposition to such legalization at this time."

The House also accepted a recommendation from the Medical-Legal Council that it not endorse a proposal that medicine help set up a peer review mechanism for lawyers. This proposal was presented to the House in 1974 and referred to the council for its study and recommendation.

VIII. COMMITTEE G (Public Relations, Membership and Miscellaneous Business)

The House took the following actions:

A. Rejected a resolution calling for ISMS to recognize the concept of an independent union of physicians.

B. Agreed that a survey of component medical societies be made to evaluate the present trustee districts and that ISMS continue to study whether these districts can be changed to make them more representative of their areas.

C. Requested component societies to encourage local housestaff membership and participation on the various internal committees of the component societies.

D. Directed the Board of Trustees to refer to an appropriate committee the matter of determining when life begins and ends so that the medical profession can inform the public of the doctor's views.

IX. COMMITTEE H

Reference Committee H was established to consider a position paper from the Chicago Gray Panthers. After hearing testimony from members of this organization, the reference committee recommended, and the House agreed to:

A. Instruct its AMA Delegation to submit at the 1975 annual meeting a resolution calling for reactivation of the Committee on Aging and Community Health.

B. Direct the ISMS Council on Education and Manpower, through its contacts with the medical schools, to urge curriculum inclusion of courses in geriatrics and to prepare a resolution for submission to the AMA House of Delegates which would effect activity in this direction at the national level.

Actions on Resolutions 1975 House of Delegates

Number	*Introduced By:*	*Subject*	*Action*
75A-1	Jos. L Bordenave	Continued Funding for ICCME	Adopted
75A-2	Charles J. Jannings	Formation of Independent Union of Physicians	Rejected
75A-3	A. E. Livingston	Amendment to Bylaws Chapter I—Membership	Adopted
75A-4	A. E. Livingston	Amendment to Bylaws	Withdrawn
75A-5	A. E. Livingston	Amendment to Chapter IX of the Bylaws	Adopted
75A-6	A. E. Livingston	Amendment to Chapter XI of the Bylaws	Adopted as amended
75A-7	Theodore Grevas	Assistance for PSRO Organizations	Rejected
75A-8	Jack Gibbs	Malpractice Insurance Coverage	Substitute adopted as amended
75A-9	Jos. R. O'Donnell	Officer Elections	Rejected
75A-10	Jos. R. O'Donnell	Redistricting	Adopted as amended
75A-11	A. E. Livingston	Amendment to Chapter VII of the Bylaws	Adopted
75A-12	Eugene Vickery	Use of Package Insert	Substitute adopted
75A-13	Eugene Vickery	Non-Endorsement of Resolution 74A-51	Adopted
75A-14	Kermit Mehlinger	Psychosurgery	Adopted as amended
75A-15	Eugene L. Vickery	Professional Liability	Rejected
75A-16	Kermit Mehlinger	Community Mental Health Center Suport	Substitute adopted
75A-17	Kermit Mehlinger	Reaffirmation of Position Regarding Diagnosis & Treatment of Mental Disorders	Substitute adopted
75A-18	Kermit Mehlinger	Medical Services by Non-Physicians	Adopted as amended
75A-19	Kermit Mehlinger	Equalization of Medicare Benefits for Psychiatric Illness	Combined with 75A-20 & substituted adopted
75A-20	Kermit Mehlinger	Inclusion of Mental Illness under any National Health Insurance	Combined with 75A-19 & substitute adopted
75A-21	James P. Campbell	Relationship of Medical Diagnosis to Prognosis & Treatment	Substitute adopted

Number	*Introduced By:*	*Subject*	*Action*
75A-22	Edward G. Ference	Pursuit of No Fault Professional Liability Insurance through State & Federal Legislation	Rejected
75A-23	Robert P. Johnson	Peer Review	Rejected
75A-24	James W. Sutherland	Limitation of Practice of Acupuncture to Fully Licensed M.D.s & Osteopaths	Substitute adopted with editorial change
75A-25	Herman Wing	Confidentiality & PSRO	Substitute adopted with editorial change
75A-26	Wayne N. Leimbach	Malpractice Claims	Substitute adopted as amended
75A-27	Jacob E. Reisch	Amendment to Article VIII of the Constitution	Adopted
75A-28	Howard C. Burkhead	Minimum Size of Chartered Component Societies	Considered with 75A-39 & rejected
75A-29	Howard C. Burkhead	Vote of Officers & Trustees in H of D	Rejected
75A-30	A. Boba	ISMS Position on Hospital Credentialing Criteria with Reference to Professional Liability	Substitute adopted
75A-31	Fredric D. Lake	Amendment to the Constitution & Bylaws	Adopted
75A-32	Allan L. Goslin	Response to Resolution 74A-53	Rejected
75A-33	Ronald T. Staubly	Promotion of ISMS Component Society Housestaff Participation	Substitute adopted
75A-34	David S. Fox	Membership for First Year Medical Students	Adopted as amended
75A-35	H. Frank Holman	Determination of When Life Begins	Substituted adopted
75A-36	Eugene P. Johnson	Payment of Dues to AMA	Late resolution. Not accepted for introduction
75A-37	Eugene P. Johnson	Public Statements of Officers	Late resolution. Not accepted for introduction
75A-38	Eugene P. Johnson	Obligations of AMA Delegates	Late resolution. Not accepted for introduction
75A-39	J. M. Ingalls	Composition of the House of Delegates	Considered with 75A-28 & rejected
75A-40	J. M. Ingalls	Illinois Delegation to the AMA	Substitute adopted
75A-41	J. M. Ingalls	Leadership Workshop for County and CMS Branch Officers	Adopted
75A-42	J. M. Ingalls	Semi-Annual Meeting of the House of Delegates	Referred to Board of Trustees & Finance Comm.—Report back to 1976 H of D

Number	*Introduced By:*	*Subject*	*Action*
75A-43	Jos. L. Bordenave	Medical Representative on Boards of Other Organizations	Accepted
75A-44	Eugene P. Johnson	Nomination of Dr. Willard C. Scrivner as "Senior Statesman"	Withdrawn
75A-45	E. T. Leonard	Redistricting	Adopted
75A-46	Guy Pandola	Marihuana Legislation	Substitute adopted
75A-47	Jeffrey Waitzman	Election of Student Delegates & Alternate Delegate	Adopted
75A-48	Jeffrey Waitzman	MECO	Adopted
75A-49	Jeffrey Waitzman	Continued Funding for Liaison with Students, Interns & Residents	Adopted
75A-50	E. K. DuVivier	Peer Review Plan for Hospital Emergency Room	Substitute adopted
75A-51	Allan L. Goslin	Use of Federal Funds for ISMS-Approved Activities	Rejected
75A-52	Guy Pandola	Health Insurance Coverage for Psychiatric Disorders	Substitute adopted
75A-53	John J. Ring	Mechanism for On-Going Review of Redistricting Recommendations	Adopted as amended
75A-54	John J. Ring	Amendment to Chapter V, Sec. 3 of the Bylaws	Adopted as amended
75A-55	A. Beaumont Johnson	Utilization Review of Governmental (VA) Hospitals by ISMS	Adopted as amended & editorially changed
75A-56	Jacob Reisch	Honorariums for Pres., Pres-Elect, Chairman of the B of T	Substituted as amended

Special Actions

Motion to Amend Chapter VII, Sec. 1.

Entitling District 1A and District 3 to one additional Trustee each, for a two year trial period. — Adopted

75A-Emergency Resolution

Election of additional Trustees from Districts 1A and 3 — Adopted

Supplemental Report #1 of the Secretary-Treasurer

Resolution presented by the Reference Committee. Members who have not paid the special assessment be notified that failure to do so jeopardizes their membership in the Society. — Adopted as amended

Report of Select Committee

Report was referred to the Board of Trustees for its consideration and action. Board to report back to the House at its next meeting. — Adopted


CONVENTION
FACES

Abstracts of Board Actions

(Continued from page 418)

of the University of Chicago Hospitals and Clinics, the committee has representatives of the Chicago Medical Society, Chicago Hospital Council, Illinois Division of the American Cancer Society and the Chicago and Illinois Radiological Societies.

ISMS has distributed to all Illinois physicians an explanation of the problem and suggested management guidelines for patients with a history of irradiation to the head and neck during childhood; the IHA distributed similar information to its members, and the Cancer Society has prepared a public message for Illinois news media.

Illinois Health Facilities Plan

The Board reaffirmed its support of the principle of Certificate of Need and took no position on the proposed Illinois Health Facilities Plan.

State Appointments

As a result of nominations from the ISMS Executive Committee, the following have been appointed to Illinois Department of Public Health advisory boards: Dr. Alfred J. Clementi, Palatine, Advisory Committee to Hospital Licensing Board; Dr. Donald Hajek, Rockford, Clinical Laboratory and Blood Bank Advisory Board; and Dr. Eugene L. Vickery, Lena, Ambulatory Surgical Treatment Center Licensing Board. Dr. James F. Kurtz, La Grange, nominated to replace Dr. Harold A. Sofield, Oak Park, on the Secretary of State's Driver's License Advisory Committee.

TAP-MATS Institute and Seminar on Death and Dying

At the request of the Illinois Hospital Association, ISMS will co-sponsor a TAP-MATS Institute May 1 and 2 in Decatur. It will also co-sponsor a seminar on "Death and Dying" April 16 in Hillside. Other co-sponsors are the Funeral Directors Association, Illinois Nursing Home Association and Illinois Department of Mental Health and Developmental Disabilities.

Nominees for AMA Appointment

ISMS has submitted the following nominations for AMA committees: Dr. Morgan Meyer, Lombard, Coordinating Council on Medical Education; Dr. N. K. Furlong, Peoria, Liaison Committee on Graduate Medical Education; and Drs. Dean R. Bordeaux, Peoria, Maynard I. Shapiro, Chicago, and Fred Z. White, Chillicothe, for the Residence Review Committee for Family Practice.

Dr. William Lees was nominated for appointment to the AMA Judicial Council and if a vacancy does not exist there, his name will be submitted as a nominee for election to the Council on Long Range Planning. The Executive Committee was requested to decide whether or not ISMS will nominate anyone for election to the Council on Medical Education.

AMA Conferences

Dr. William Lees will attend the AMA Conference on the Disabled Doctor, April 11-12, in San Francisco, and Dr. George Wilkins, will be the ISMS representative at the Ninth Annual Socio-Economics Congress April 25-26 in Atlanta.

Scrivner Appointed Special Consultant

Dr. Willard C. Scrivner, past president of ISMS, has been appointed the Board's special consultant on federal legislation affecting health care.

Other Legislation

The Board approved a proposed amendment to the rate review legislation which would specifically exempt physicians' services from the bill. Legal counsel was instructed to develop appropriate language clarifying "hospital based programs" for a proposed amendment to the Insurance Code, which would provide for optional inclusion of mental health coverage in all health insurance policies in Illinois.

ISMS will also:

Oppose HB 11, Death with Dignity, because there is no definition of terminal illness; it implies that physicians do not involve the patient and families in decisions regarding care, there is no provision for rights of next of kin, the bill raises serious liability questions, and the "living will" seems to make additional legislation unnecessary.

Oppose HB 208—which prohibits experimentation on a fetus—because it would severely restrict medical research.

Oppose HB 265—which establishes new grounds for suspension of license under the Medical Practice Act—and urge the Joint Commission on Accreditation of Hospitals and the Illinois Department of Public Health to enforce the JCAH guidelines on informed consent.

Oppose HB 266—which would require the presence of a radiologist on duty in all hospitals at all times—because regional trauma centers already are required to have a radiologist on call at all times.

Support HB 347 and 348—which would establish and fund a medical student loan program—pending acceptance of amendments which would allow graduates to defer their service requirement until completion of a residency program and allow graduates to pick their service area from among those listed by the Department of Public Health.

Support in principle HB 414 and 415, which would establish a Medical School Admission Study Commission.

Support HB 611 which would eliminate the 2½ years retention requirement for X-ray films—pending approval of an amendment requiring that films be retained for one year prior to minification.

Oppose HB 618—which would require MDs to cease extraordinary life prolonging measures in certain instances—and offer ISMS services to legislative subcommittee studying this subject.

Support HB 644, Fee Schedules for Department of Public Aid, if the bill retains the provision for paying physician's bills in 90 days.

Take no position on HB 780—which would allow IDPH to close any surgicenter without hearing if it poses a danger to the health of its patients—because closing ambulatory surgical centers without due process would be unconstitutional.

Support amended version of SB 27, which prohibits any health insurance policy to disclaim coverage for newborn infants.

Oppose HB 203, Cancer Advisory Council, on the grounds that it duplicates services currently being offered by the American Cancer Society and is therefore an unnecessary expense on the part of state government.

Reaffirm opposition to SB 250 and 254, which would permit chiropractors to perform school physicals and test for sickle cell anemia.

Refer to the Council on Education and Manpower for further study a request from Dr. Eli Borkon for legislation that would enable medical schools to retrain some 60,000 non-working registered nurses as physicians assistants.

Refer to Government Affairs Council a recommendation that the Medical Practice Act be amended to remove the requirement that a physician from another state, applying for a temporary license in order to begin a residency in Illinois, certify that he does not intend to practice in Illinois.

Notify the Board of Higher Education that ISMS approves participation in its response to SJR 65, which was introduced by Senator Partee in the 1974 legislature.

Student and Resident Expenses at AMA Meeting

ISMS again will sponsor attendance at the AMA annual meeting, by two students and two residents, with a total of $1,200 being allocated for this purpose from the dollar assessment to provide liaison with these groups.

Resignation of Dr. David Fox and Re-Election of Dr. Bordenave

The Board reluctantly accepted the resignation of Dr. David S. Fox, Third District Trustee, and re-elected Dr. Joseph L. Bordenave to another one-year term as Chairman of the Board of Trustees. ◄

Dangerous Drugs Commission Carries Out State Plan

The Drug Abuse Office and Treatment Act of 1972 (PL 92-255) made federal funds available to the states for the purpose of combating drug abuse. In order to receive such funds, a state must submit a plan for implementing and evaluating an effective program for drug abuse prevention, treatment, and rehabilitation. Further, a single state agency must be established as the sole agency for the preparation and administration of the plan and allocation of funds.

The Dangerous Drugs Abuse Act, passed by the Illinois legislature in 1967, created the Dangerous Drugs Advisory Council. Pursuant to federal guidelines, the Act was amended in 1974 to establish the Dangerous Drugs Commission, designating it the single state agency to coordinate and administer drug abuse prevention, treatment and rehabilitation programs. The Commission works in cooperation with other state and federal agencies as well as public and private organizations. The Dangerous Drugs Advisory Council makes recommendations and advises the Commission in carrying out the state plan.

As the state planning agency for drug abuse functions, the Dangerous Drugs Commission is delegated the responsibility of developing and implementing an annual comprehensive state plan to reduce drug abuse and establish priorities in administering federal and state funds provided to support drug abuse programs.

In coordinating state and federal funding of drug abuse functions, the Commission is authorized to make grants-in-aid and purchase care agreements with both governmental and private agencies.

The Dangerous Drugs commission also licenses and regulates all drug treatment, education, prevention and rehabilitation programs in the state, except those conducted within a licensed hospital. The Commission sets treatment standards and issues rules and regulations for the operation of drug abuse programs.

Since reliable and timely data is essential in evaluating the effectiveness of drug abuse treatment and rehabilitation methods, the Information Services Division of the Commission continually collects, analyzses and applies data concerning clinical operations (medical work-ups, demographics) and regulatory methadone maintenance (counseling, toxicology, prescription dosages.) The division also keeps a weekly statewide log for methadone clinics, a continuing inventory of drug abuse program resources, and a bank of research data on treatment modalities. All information is strictly confidential.

The Toxicology Division of the Dangerous Drugs Commission is the state laboratory facility which provides drug abuse tests to the state's total client population. The lab is subject to the regulations and standards set by the FDA, the National Institute of Drug Abuse and the Commission itself.

The Dangerous Drugs Commission is located at Marina Towers, 300 N. State St., Chicago, 60610. Phone (312) 793-3840.

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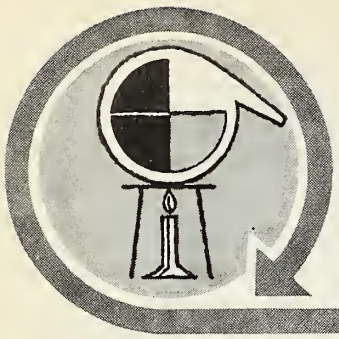
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new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

CALCIMAR — Polypeptide Hormone Rx

Manufacturer:	Armour Pharmaceutical Co.
Nonproprietary Name:	Calcitonin-Salmon
Indications:	Symptomatic treatment of Paget's disease of the bone.
Warnings:	Use with caution in women who are or may become pregnant. Do not administer to nursing mothers.
Dosage:	Refer to package insert.
Supplied:	Powder, 400 MRC Units with 20 mg gelatin.

CYLERT — Psychostimulant Rx

Manufacturer:	Abbott Laboratories
Nonproprietary Name:	Pemoline
Indications:	Minimal brain dysfunction in children.
Warnings:	Not recommended for children under six years of age. Use caution in children with significantly impaired renal function.
Dose:	Single dose each morning, starting with 37.5 mg and gradually increased by increments of 18.75 mg.
Supplied:	Tablets, 18.75, 37.5 and 75 mg.

ISOPAQUE 280 and 440 — Contrast Media Rx

Manufacturer:	Winthrop Laboratories
Nonproprietary Name:	Metrizoates 280 Meglumine and Calcium 440 Meglumine, Calcium Magnesium and Sodium
Indications:	280—Excretory urography, selective angiography and peripheral arteriography. 440—Angiocardiography, aortography and arteriography.
Contraindications and Precautions:	See package insert.
Dosage:	See package insert.
Supplied:	280—Vials, 20 and 40 ml. 440—Vials, 50 ml.

DUPLICATE SINGLE DRUGS

ARISTOCEL — Corticoids Local Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Triamcinolone Acetonide
Indications:	Inflammatory manifestations of corticosteroid-responsive dermatoses.
Contraindications:	Those usual with corticosteroids.
Administration:	Apply to affected areas 3 or 4 times daily.
Supplied:	Tubes, 15 and 75 Gm, 0.1% Gel

DRYSOL — Dermatological Preparation Rx

Manufacturer:	Person & Covey, Inc.
Nonproprietary Name:	Aluminum Chloride 20% SD Alcohol 40 80%
Indications:	Aid in the management of hyperhidrosis.
Warnings:	Discontinue when irritation or sensitization occurs.
Dosage:	Apply to affected area prior to sleep.
Supplied:	Polyethylene bottle, 37.5 mg.

JANIMINE — Psychostimulant Rx

Manufacturer:	Abbott Laboratories
Nonproprietary Name:	Imipramine HCl
Indications:	Endogenous and other forms of depression.
Contraindications and Warnings:	Refer to package insert.
Dosage:	Refer to package insert.
Supplied:	Tablets, 10, 25 and 50 mg.

MISTURA C — Parasympathomimetic Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Carbachol
Indications:	Reduction of intraocular pressure in open-angle or narrow-angle glaucoma.
Contraindications:	Corneal abrasion and acute iritis.
Dosage:	One mist application 2 or 3 times daily.
Supplied:	Bottles, 15 ml mist dispensing.

MISTURA D — Eye Preparations Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Phenylephrine HCl 0.12% with stabilizing agents.
Indications:	Minor eye irritations, associated with hay fever, colds, dust, wind, sun, smog or hard contact lenses.
Contraindication:	Narrow-angle glaucoma.
Dosage:	One mist application, repeated in 3 or 4 hours as needed.
Supplied:	Bottles, 15 ml mist dispensing.

MISTURA E — Eye Preparations Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	l-Epinephrine with stabilizing agents.
Indications:	Chronic simple glaucoma.
Contraindications:	Attack of narrow-angle glaucoma.
Dosage:	One mist application once or twice daily.
Supplied:	Bottles, 15 ml mist dispensing. Strength, 0.25, 0.5, 1 and 2%

MISTURA P — Eye Preparations Rx

Manufacturer:	Lederle Laboratories
Nonproprietary Name:	Pilocarpine HCl (Benzalkonium 1:25,000 and stabilizing agents)
Indications:	Control of intraocular pressure in glaucoma. Emergency relief of mydriasis. Follow up treatment with cycloplegics to reverse mydriasis.
Dosage:	Glaucoma—1 mist application four times a day. Miosis—1 mist application of the higher concentration. Mydriasis—depending on cycloplegic used.
Supplied:	Bottles, 15 ml mist dispensing Strength, ½, 1, 2, 3 and 4%

COMBINATION PRODUCTS

MATERNA 1.60 — Multiple Vitamins and Minerals Rx

Manufacturer:	Lederle Laboratories
Composition:	Multiple Vitamins
	Folic acid 1 mg
	Calcium Carbonate 350 mg
	Potassium iodide 0.3 mg
	Ferrous fumarate 60 mg
	Magnesium oxide 100 mg
	Cupric oxide 2 mg
	Zinc oxide 15 mg
	Sod. sulfosuccinate 50 mg
Indications:	Pregnancy and lactation.
Supplied:	Film coated tablets.
Dosage:	1 Tablet daily or as prescribed.

MISTURA D.Zn — Eye Preparations Rx

Manufacturer:	Lederle Laboratories
Composition:	Zinc Sulfate 0.25%
	Phenylephrine HCl 0.12%
	with stabilizing agents.
Indications:	Minor eye irritations, associated with hay fever, colds, dust, wind, sun, smoke etc.
Contraindications:	Narrow-angle glaucoma.
Dosage:	One mist application three or four times daily.
Supplied:	Bottles, 15 ml mist dispensing.

WYGESIC — Nonnarcotic Analgesic Rx

Manufacturer:	Wyeth Laboratories, Inc.
Composition:	Propoxyphene HCl 65 mg
	Acetaminophen 650 mg
Indications:	Mild to moderate pain, occurring alone or accompanied by fever.
Warnings:	Possibility of drug dependence to propoxyphene.
Dosage:	One tablet every four hours.
Supplied:	Tablets

Obituaries

***Avery, Edward,** Chicago, died Feb. 12. Dr. Avery was a thoracic surgeon.

****Asbury, Ernst,** New Baden, died Feb. 8, at the age of 86. He graduated from St. Louis University in 1915. Dr. Asbury has practiced medicine in New Baden for over 50 years.

***Davis, Paul,** Park Ridge, died Feb. 17 at the age of 79. Dr. Davis graduated from the Chicago Medical School in 1930.

***Dandenault, A. G.,** Rockford, died March 18 at the age of 76. Dr. Dandenault graduated from the University of Manitoba, Canada in 1926.

***Feinsot, Irving,** Calumet City, died Feb. 11, at the age of 77. He graduated from Chicago Medical College in 1930. Dr. Feinsot served as the city's health officer for Calumet City.

Felicetti, Theresa, Chicago, died Feb. 25 at the age of 75. Dr. Felicetti has been a Chicago physician for more than 50 years.

****Fisher, Hart,** Chicago, died March 11 at the age of 89. Dr. Fisher graduated from Hahnemann Medical College in 1912.

****Gordon, Richard,** Chicago, died Feb. 26 at the age of 77. He graduated from Northwestern University in 1924. Dr. Gordon has served on the staff of St. Joseph's for the past 10 years.

***Grundset, Lloyd,** Waukegan, died Feb. 12, at the age of 54. He graduated from the College of Medical Evangelist in 1944. Dr. Crundset was medical director of the out-patient clinic ond senior teaching instructor at Mt. Sinai Hospital.

***Jackson, Arthur, E.** St. Louis, died March 4, at the age of 60. Dr. Jackson graduated from the Meharry Medical College in 1940.

***Milzer, Albert,** Chicago, died March 5 at the age of 59. Dr. Milzer graduated from Northwestern University in 1950. Dr. Milzer was a key member of a research team at Michael Reese which developed a vaccine that killed the polio virus by the ultraviolet radiation.

***Patchanian, Giragos,** died Feb. 25 at the age of 83. Dr. Patchanian has practiced medicine for over 50 years.

***Warren, Harry,** Peoria, died Feb. 9 at the age of 65. He graduated from Northwestern University in 1934. Dr. Warren was a Diplomat of the American Board of Internal Medicine and on the staff of St. Francis hospital in Peoria.

***Walters, Orville,** Urbana, died Feb. 16 at the age of 72. He graduated from St. Louis University in 1939. Dr. Walters was a former head of the University of Illinois health service.

***Widenhorn, Hans,** Chicago, died Feb. 26 at the age of 73. Dr. Widenhorn graduated from Ludwig University in 1926.

Wolf, Arnold, Highland Park, died Feb. 27 at the age of 58. Dr. Wolf graduated from the Rochester School of Medicine in 1942. Dr. Wolf was dean of the graduate college, University of Illinois since Jan. 1973.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

Viewbox

(Continued from page 426)

DIAGNOSIS: There is a posterior dislocation of the body of C-5 on C-4. The superior facet of C-5 is displaced posteriorly on the inferior facet of C-4 with compression of the cord. This is one of the hazards of snowmobiling.

EKG

(Continued from page 451)

Answers: 1. A, B, E 2. A, B

The QRS in the top two panels is slightly wider than normal, and ST segment elevation is present. The fifth beat from the right in the middle panel may be a fusion beat. The vertical bars over the ECG in the top and middle panels point to P waves. Some sinus arrhythmia is present, but it is clear the atria and ventricles are dissociated; i.e. beating independently of each other.

This is ventricular tachycardia. Severe hypotension need not accompany ventricular tachycardia. This is probably related to the site or focus of the centricular tachycardia. If the focus is reasonably located in the ventricles, a near normal sequence of cardiac activation and contraction may occur. Treatment would include direct current cardioversion, occasionally with low energy levels as in this case, twenty-five watt seconds. (See bottom panel of ECG). An arrhythmia suppressant drug like procainamide would also be indicated to prevent recurrences of the ventricular tachycardia.

Self-Assessment Programs

One of the most popular and useful means for determining your CME needs is to use one of the SELF-ASSESSMENT PROGRAMS offered for various specialties (including Family Physicians). For full information on programs currently available, request the *Directory of Self-Assessment Programs for Physicians* from . . .

Leo Leveridge, M.D.,
Assistant Director
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Division of Medical Education
AMERICAN MEDICAL ASSOCIATION
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PROLOID® (thyroglobulin)
Caution: Federal law prohibits dispensing without prescription.
Description. Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, Sodium Levothyroxine (T_4) and Sodium Liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.
Chromatographic analysis to standardize the Sodium Levothyroxine and Sodium Liothyronine content of Proloid (thyroglobulin) is routinely employed.
The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.
Proloid (thyroglobulin) is stable when stored at usual room temperature.
Indications. Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.
In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.
Contraindication. Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.
Warnings. Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.
Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.
Myxedematous patients are very sensitive to thyroid and dosage should be started at a very low level and increased gradually.
Precaution. As with all thyroid preparations this drug will alter results of thyroid function tests.
Adverse Reactions. Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.
Dosage and Administration. Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, $T_3{}^{131}I$ resin sponge uptake, $T_3{}^{131}I$ red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.
Instructions for Use. The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

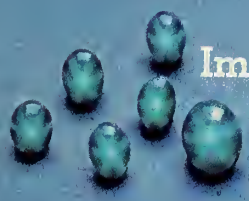
CONVERSION TABLE

Dose of Proloid (thyroglobulin)	Dose of Desiccated Thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

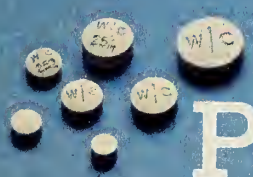
In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.
Overdosage Symptoms. Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.
(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)
Supplied. ¼ grain tablets in bottles of 100 (N 0047-0250-51) and 1000 (N 0047-0250-60); ½ grain tablets in bottles of 100 (N 0047-0251-51) and 1000 (N 0047-0251-60); scored 1 grain tablets in bottles of 100 (N 0047-0252-51) and 1000 (N 0047-0252-60); 1½ grain tablets in bottles of 100 (N 0047-0253-51) and 1000 (N 0047-0253-60); scored 2 grain tablets in bottles of 100 (N 0047-0257-51); 3 grain tablets in bottles of 100 (N 0047-0254-51) and 1000 (N 0047-0254-60); scored 5 grain tablets in bottles of 100 (N 0047-0255-51) and 1000 (N 0047-0255-60). Full information is available on request. P-GP-51 4/c

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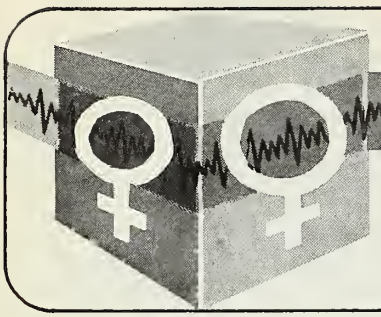
natural thyroid...but uniquely purified
Devoid of any glandular debris.

natural thyroid...but triply standardized
Standardized chemically, biologically, and (at intervals) clinically, for consistent metabolic activity from batch to batch.

natural thyroid...but consistently fresh
Potency undiminished for up to 4 years under proper storage conditions.

It all adds up to natural thyroid with the added improvements of man.

Please see adjoining column for brief summary of prescribing information.



pulse... of the doctor's wife

Mrs. Harold Keegan, Editor

Humanitarian Award

The first presentation of the *Humanitarian Award* was made at the 47th Annual Meeting of the ISMS Auxiliary held April 1-4, 1975, in Chicago. Mrs. Clement Cunningham, Chairman of Religion & Medicine, presented the award to Mrs. Edward J. Matson of Libertyville, Executive Director of the Grove School for Handicapped Children. Mrs. Matson founded the Grove School in November 1958, for "children with no place to go to school." She really had no idea of starting any large project, but thought she would help until the public schools would take over their responsibilities of educating handicapped youngsters.



Mrs. Matson

Almost seventeen years later over a thousand handicapped children have passed through the school. The present population of the school is 127 children. In those seventeen years Mrs. Matson has been active in setting up legislation to improve the lot of all handicapped children in the State. She wrote some of the first drafts for mandatory special education which was passed in 1965 and took effect in 1969. She also wrote the landmark bill known as H. B. 2674, which states that if a public school is unable to set-up classes for certain handicapped children they must send them to appropriate private programs.

In 1964 Mrs. Matson began planning an ideal facility for young people which would combine home care, skilled and restorative nursing. Ten years later this building is now a reality and caring for 45 young people. Mrs. Matson has traveled extensively, lectured and authored several books. Her latest book is titled A School for Peter.

The philosophy of Mrs. Matson's program is to reach all aspects of a child's needs and help him to improve in every possible way—health, activity and overcoming specific handicaps; feeling and acting emotionally secure and loved; developing the talents and unique skills which he alone may possess, whether it is to be loved or to love others; or going on to do useful tasks in his community; and to make every personal effort to be a good citizen, serve where and how he can, and believe in his own personal worth.

Congratulations Mrs. Matson!

President and President-Elect

Introducing Mrs. Eugene Vickery (Millie) of Lena, the new president of the Illinois State Medical Society Auxiliary and Mrs. John Ovitz (Jane) of Sycamore, the new president-elect of ISMS Auxiliary. All officers were installed April 3, 1975, during the Annual Convention of the ISMS Auxiliary in Chicago.



Mrs. Ovitz, President-Elect, and Mrs. Vickery, President, holding the needlepoint emblem of the Auxiliary which was designed, made and presented by Mrs. Joseph Santiago of Belleville (District 10 Councilor).

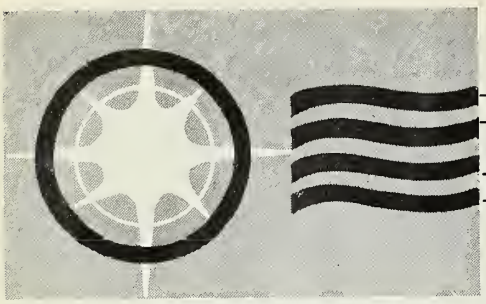
The 1975-76 Board of ISMS Auxiliary



First row (left to right): Mrs. George Wardle, Mrs. Leo Kempton, Mrs. William Hodges, Mrs. Thomas Glatter, Immediate Past President; Mrs. John Ovitz, President-Elect; Mrs. Eugene Vickery, President; Mrs. Ralph Davis, Mrs. Earl V. Klaren, Mrs. Edward Szeivezyk, Mrs. L. Paul Johnson, Mrs. Paul P. David.

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membership forum

March 24, 1975

Dear Editor:

Again, this year I am compiling case reports of allergic reactions to biting insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the type of reaction and complications, if any, the age, sex, and race of the patient, the site of the bite (s), the season of the year, the immediate symptoms, the skin test results, desensitization results, if any, and any associated other allergies. Send this information to the following address:

Claude A. Frazier, M.D.
4-C Doctors' Park
Asheville, N.C. 28801

Thank you for your assistance.

Sincerely,
Claude A. Frazier, M.D.

PHYSICIANS WANTED

Specialist and Generalists working together to make the Hartford area a better place to live and practice medicine. Thirteen physicians presently serve the area in two clinics and also solo practice—there is a need for more physicians to serve this fast growing area—specifically in Family Practice and Internal Medicine. A new hospital building has been completed and will provide the best facilities possible. The service area population is over 30,000, while Hartford is a community of 7,000 and part of the metropolitan Milwaukee Planning Area, less than 30 minutes away from major cultural, educational and social resources. Hartford and its outlying communities offer more of a rural community flavor with proximity to lakes, ski hills and other recreational advantages. This invitation to Hartford, Wisconson is the co-operative effort of the physicians, clinics, hospital and interested community leaders. Contact the Hartford Community Physician Research Committee by letter or phone, through N. K. Reynolds, at Hartford Memorial Hospital, 1032 E. Sumner, Hartford, Wisconsin 53027, (414) 673-2300.

Dear Editor:

In February '75 MEDICAL WORLD NEWS (page 106) there was a poem titled "Dr. and Mr. ——" lamenting that "The Auxiliary still won't take those of my sex" by Pedro Saavedra whose wife is an internist. Here is his answer . . . come to Illinois! April 2, 1975 at the state convention of the "Woman's Auxiliary to the Illinois State Medical Society" . . . new by-laws were adopted changing the name (omitting Woman's) to read ILLINOIS STATE MEDICAL SOCIETY AUXILIARY. Doctor's husbands are welcome to join now! The following poem is the answer to Medical World News "Dr. and Mr."

Mrs. Eugene L. Vickery
President, Illinois State
Medical Society Auxiliary

"WOMAN'S AUXILIARY"

In Illinois, praise the Lord,
The ladies of their own accord
Have dropped the female designation—
Hence for full participation
Now expect each masculine
Devoted spouse to enter in
And help with all the far-flung duties
Carried by Auxiliary beauties.
No more can he of male persuasion
Use his sex for smooth evasion!
Now a spouse of either gender
Can hope to be a full extender
Of healthful help and real support
Developing a new rapport
With doctors and their patients, too,
In a spirit bright and new.

—Eugene L. Vickery, M.D.

Editor's Note: The name of the senior author, Eve Arlin Gelperin, M.S. Ed., M.S.N., was inadvertently left off of the guest editorial "A Retrospective View of Nursing and Medical Practice", in the April issue of the IMJ.

CORRECTION: In the recent mailing by CAVDA there was a mistake in the dosage listed for Vibramycin. The correct dosage is 0.9 gms.: 9 capsules of 100 mgs. given 3 the first day and one B.I.D. till gone.

Doctor's News

A MALPRACTICE CRISIS CENTER has been established in Springfield by the ISMS Task Force on Professional Liability to coordinate activities for the passage of malpractice legislation. The center briefs those doctors who come to the Capitol City on the bills concerned with malpractice. Then the physicians proceed one block to the Capitol where they speak with senators and representatives about the need for malpractice legislation. The Crisis Center will remain in Springfield until action has been taken on all bills concerned with malpractice.

Physicians are urged to spend a day in Springfield. Information about flight schedules and the bills to be acted upon can be obtained from the Crisis Center office at the State House Inn, 101 E. Adams, Springfield. Phone (217) 523-5661.

If you can't come to Springfield, send a telegram to your congressman **now!**

NON-SMOKERS HAVE RIGHTS TOO, PLEASE DON'T SMOKE, reads a poster available free to members of the medical profession from the Illinois Interagency Council on Smoking and Disease. The agency has various display materials which are designed to help physicians cut down this health hazard and annoyance by reminding smokers to not contaminate the air where others must be to seek medical services. Request these materials from: Illinois Agency Council on Smoking and Disease, 22 West Madison Street, Room 506, Chicago, 60602.

12th MIDWEST ANESTHESIOLOGY CONFERENCE (MAC XII) of the Illinois Society of Anesthesiologist will be held May 29-31, at the Sheridan Chicago Hotel, Chicago. The theme of the conference is "Anesthesia and the Cardiovascular System." Clinical workshops and lectures by outstanding anesthesiologists and other clinicians foremost in their field will be given. There is also a special symposium for Recovery Room nurses. Co-chairmen for the meeting are Dean H. Morrow M.D., and Anthony D. Ivankovich, M.D. To register contact: Ronald F. Albrecht, Ill. Soc. of Anesthesiologists, c/o Dept. of Anesthesiology, Michael Reese Medical Center, 2900 S. Ellis Ave., Chicago, 60616.

"CALL AN AMBULANCE FOR THAT DRUNK LINING THE DOORWAY," says Senate Bill 1674 (P.A. 78-1270). In preparation for the enactment of this bill July 1, 1975, the Central States Institute of Addiction Programs has designed a comprehensive one day training module, Emergency Room Management and Treatment of Acute Alcoholism, to help prepare Illinois medical personnel for this health care crisis. The seminar will be conducted on May 16 and 23, and June 13 and 20. For further information contact: Central States Institute of Addiction, 122 South Desplaines Street, Chicago, 60606.

AMERICAN HOSPITAL BECOMES THOREK MEDICAL CENTER—The 250-bed community hospital located at 850 W. Irving Park Road, Chicago, was renamed after its founder, the late Dr. Max Thorek, a noted surgeon, musician, photo enthusiast, and educator. Dr. Thorek also founded the International College of Surgeons.

THE MEDICAL MANAGEMENT OF ALCOHOLISM program scheduled for May 28, at the LaSalle Hotel in Chicago, has been cancelled. Please watch for announcement of future date.

FORD FOUNDATION GRANTS $242,000 to the Illinois Department of Mental Health and Developmental Disabilities to help continue a program to improve the teaching of elementary school pupils, including those with learning disabilities and those with emotional or behavioral problems. This program, operated by the Institute for Juvenile Research in cooperation with Hull House Association, involves approximately 650 children at Nettelhorst Elementary School on Chicago's mid-north side and plans also to include high school students from nearby schools.

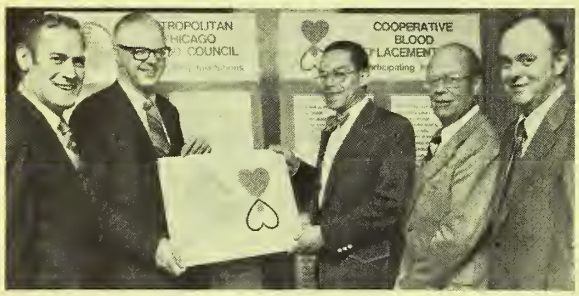
ILLINOIS STATE SOCIETY OF RADIOLOGIC TECHNOLIGISTS will hold its 40th Annual Meeting at the Holiday Inn in Collinsville on Thursday, October 9, through Saturday, October 11, 1975.

PHYSICIANS IN THE NEWS—Leon I. Jacobsen, M.D., Dean of the Pritzker School of Medicine, University of Chicago, was awarded the John Philips award for distinguished contributions in internal medicine by the American College of Physicians at their annual meeting.

The new Deputy Director of Clinical Services and Programs for the Illinois Department of Mental Health and Developmental Disabilities is **Ivan Pavkovic, M.D.** He succeeds **Patrick R. Staunton, M.D.,** who has been named Chief of Psychiatric Services, Veterans' Administration Hospital, Hines, Illinois.

Fernando Lopez-Fernandez, M.D., Medical Director and Chairman, Continuing Medical Education, Martha Washington Hospital, has been elected a Member of the American College of Clinical Pharmacology. Dr. Lopez-Fernandez is in charge of the Drug Spotlight Program at the hospital.

Newly elected officers of the Illinois Society of Internal Medicine are **W. B. Buckingham, M.D.,** President; **Hugh S. Espey, M.D.,** President-Elect; **Donald Hanscom, M.D.,** Secretary-Treasurer. Councilors for 1974-77 are **John Coleman, M.D.; Robert M. Kark, M.D.; William Kleinschmidt, M.D.;** and **E. Richard Ensrud, M.D.**



Chicago's two leading blood organizations, the Cooperative Blood Replacement Plan and the Metropolitan Chicago Blood Council, merged into the Chicago Regional Blood Program on Tuesday, March 18. From left to right are the new officers of the organization: **John J. Gerwig,** Executive Director (formerly Executive Vice President, CBRP); **Frank E. Trobaugh Jr., M.D.,** Chairman (formerly president CBRP); **James E. Bowman, M.D.** Vice Chairman (formerly president MCBC); **S. James Schroeder,** Treasurer (formerly CBRP board member) and **William M. Walsh,** President (formerly MCBC board member). Not pictured is **Howard F. Cook,** Secretary, (formerly terasurer MCBC). The Chicago Regional Blood Program will be headquartered at the former CBRP offices at 2058 North Clark Street, Chicago, Illinois.



C. W. Mullenix, M.D., (left) President, Illinois Association of Ophthalmology presented IAO's "Man of the Year" award to **Johnny Balbo,** (right) President, International Association of Lions Clubs, on March 11, 1975. The award was presented in recognition of Lions' efforts to prevent blindness and help the visually disabled.

Housestaff News

(Continued from page 452)

uates because his friends told him that FMG's are inherantly inferior. Unilateral judgement of competency of those trained abroad on the basis of such background must be avoided.

It is apparent that there are no simple solutions to a situation that is intensely complicated and multifaceted. However, one fact stands out. In this morass, the foreign-trained physicians are in danger of being swept aside by the tidal wave of vilification. Even the shades of a return to the pre-Flexnerian era have been solemnly invoked. As housestaff, we have attempted to analyze the impact of foreign graduates on medical education and health care in this country. Our report[1] (yet another one!) argues for the elimination of double standards, discriminatory requirements and other policies that have served to isolate foreign medical graduates, alienating them both from the medical profession and from the population at large. In recommending changes in medical education and licensure practices we have insisted that FMG's be given the same rights as physicians educated domestically with complete awareness that these rights carry a corresponding series of obligations to preserve the highest quality of medical care.

On the other hand, foreign physicians are by no means completely relieved of the onus of combating assaults on their competence. The apathy of the majority has crippled initial efforts to swing the pendulum towards a more favorable climate for foreign medical graduates. This apathy must be cast aside if just and equitable solutions are to be found.

The time for action is long overdue. Repititious rhetoric and anecdotal evidence must be discarded. Intelligent, non-emotional and equitable short and long term solutions must be realized. To this end, we call upon all responsible organizations to let the dust settle so that the process of problem solving may begin.

Reference

1. Report of the Committee on House Staff Affairs: Foreigh Medical Graduates in Medical Education and Health Care in the United States: Analysis and Recommendations. American Medical Association, August, 1974.

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Congenital Absence

(Continued from page 443)

TABLE II

Hemodynamic Summary

Catheter Position	*Pressure (mmHg)*	*% O_2 saturation*
Aorta	135/75 (mean=95)	94.9
Left Ventricle	135/0 to 9	
Pulmonary Wedge	a=8, v=9 (mean=7)	
Pulmonary Artery	28/10 (mean=14)	73
Right Ventricle	27/0 to 4	
Right Atrium	a=6, v=4 (mean=3)	

Arterial Blood Gases	*Rest*	*After 100% O_2 for 10 minutes*
pO_2 (mmHg)	86.2	460
pCO_2 (mmHg)	29	22
	Hemoglobin=14.9 grams %	

Calculations	
Oxygen Consumption	=234 cc/min.
A-V Difference	=45.6 cc/L/min.
Cardiac Output	=5.1 L/min.
Cardiac Index	=3.1 L/min./M^2
Systemic resistance	=30.6 units/M^2
Pulmonary Arteriolar Resistance	=2.3 units/M^2

years is presented. Past X-rays were misinterpreted as to the diagnosis. Pulmonary scan and angiography demonstrated a unilateral absence of the pulmonary artery. No distal pulmonary artery was seen to fill through the collateral systemic circulation. A right aortic arch was also present. The patient will receive early antibiotic therapy for recurrent respiratory symptoms. ◄

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2. Idriss, F. and Dieter, R. A., Jr. "Anomalous Origin Left Pulmonary Artery in Tetralogy of Fallot and Pulmonary Scans." Submitted for publication.

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6. Oakley, C., Glick, G. and McCredie, R. M. "Congenital Absence of a Pulmonary Artery." *Amer. J. Med.* 34:264-271, Feb., 1963.

7. Byrne, R. J. R. and Bloom, D. L. "Absence of the Right Pulmonary Artery as a Cause of Hemoptysis." *J. Thor. Cardiovasc. Surg.* 59:264-268, Feb., 1970.

8. Pool, P. E., Vogel, J. H. K. and Blount, S. G., Jr. "Congenital Unilateral Absence of a Pulmonary Artery." *Amer. J. Card.* 10:706-732, Nov., 1962.

9. McKim, J. S. and Wiglesworth, F. W. "Absence of the Left Pulmonary Artery: A Report of Six Cases with Autopsy Findings in Three." *Am. Heart J.* 47:845, 1954.

10. Green, G. E., Reppert, E. H., Cohlan, S. Q. and Spencer, F. C. "Surgical Correction of Absence of Proximal Segment of Left Pulmonary Artery." *Circ.* 37:62-69, Jan., 1968.

11. Cohen, A. A., Stevens, P. M., Obenour, W. H., Bell, R. L. and Johnson, P. C. "Functional Dynamics in Unilateral Lung Disease by 133Xenon Photoscanning." *Chest* (Abstract) 58:277, Sept., 1970.

Acknowledgement

We wish to thank William Z. Langreder, M.D. for the permission to review his medical history on this patient.

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SPECIALTY REVIEW IN OB-GYN, June 2
SPECIALTY REVIEW FOR FAMILY PRACTICE, August 18
SPECIALTY REVIEW IN ORTHOPAEDICS, September 7
SPECIALTY REVIEW IN ENDOCRINOLOGY, September 8
SPECIALTY REVIEW IN MEDICAL ONCOLOGY, Sept. 8
SPECIALTY REVIEW IN CARDIOVASCULAR DISEASE, Sept. 22
SPECIALTY REVIEW IN GASTROENTEROLOGY, September 22
RADIATION ONCOLOGY, 3 days, May 15
ADVANCES IN SURGERY, One Week, May 12
SURGERY OF TRAUMA, 4 Days, June 2
SYMPOSIUM ON SHOCK, 2 Days, June 6
MANAGEMENT OF TUMORS OF HEAD & NECK, June 9
ADVANCED PERIPHERAL VASCULAR SURGERY, July 21
FLUIDS & ELECTROLYTES, One Week, Sept. 22
MANAGEMENT OF COMPLICATION IN SURGERY, Sept. 29
NEUROLOGY, CLINICAL, PART II, September 8

Information concerning numerous other continuation courses available upon request.

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

June, 1975

Coronary Rehabilitation—Exercise Testing

EXERCISE TESTING & PRESCRIBING—A PRACTICAL APPROACH
For: Practicing physicians. Symposium, June 12—3:00 PM-9:00 PM; June 13—7:45 AM-5:30 PM; June 14—7:45 AM-10:00 PM; June 15—9:00 AM-11:30 AM, Carson Inn—Nordic Hills, Itasca, IL. **CME Credit:** 21 hrs., AMA, Cat. 1, AAFP Elective. **Fee:** $150: Regular; $75: Interns, Residents, and Fellows. **Sponsor, contact:** Chgo. Heart Assoc., Coronary Care-Rehab. Subcommittee (in cooperation with North Central Regional Heart Committee of the Am. Heart Assoc.), 22 W. Madison St., Chgo. 60602, Attn.: Ms. Bette Naysmith.

Drugs

DRUG INTERACTIONS
For: MDs, Paramedics, Nurses, etc., Wkly. Seminar, June 24, 11:30-12:30, Elmhurst, IL. **CME Credit:** 1 hr., AMA Cat. 1. **Sponsor, contact:** J. Huss, MD, Dir/Med. Ed., Memorial Hosp. of DuPage County, Avon & Schiller, Elmhurst, IL 60126.

Family Medicine

NORTHERN MICHIGAN SUMMER CONFERENCE
For: (Gen. Interest), 5-day Wkshp-Course, June 23-27, Shanty Creek Lodge, Bellaire, Mich. **CME Credit:** 24 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intraumural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

FAMILY PRACTICE REVIEW-PART I
For: All MDs, 3-Day Wkshp., June 10-12, Stouffer's Inn, Indianapolis, Ind. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** Postgrad. Med. Ed., Ind. U Sch./Med., 1100 W. Mich., Indianapolis, IN 46202.

IAOP & S 76 ANNUAL CONTINUING MEDICAL EDUCATION SEMINAR & CONVENTION
For: Physicians (DO). 3-Day Seminar, June 15-18, Holiday Inn-East. Springfield, IL. **CME Credit:** 20 hrs., AOA. **Fee:** $125. Sponsor, contact: G. Andrews. Exec. Director, IL Assoc. of Osteopathic Physicians and Surgeons, 5206 S. University Ave., Chgo 60615.

ETHNIC VARIATIONS IN FAMILY THERAPY
For: MDs, etc. Lecture, June 2 12:00-2:00, Cottillion Room, Continental Plaza, Michigan/Delaware. **Speaker:** John P. Spiegel, M.D., Pres./Am. Psych. Assoc. **Fee:** $10. **Sponsor, contact:** C. Kramer, M.D., Family Institute of Chgo., 10 E. Huron, Chgo. 60611. (Phone: 440-1414).

General Medicine

INFLAMATORY BOWEL DISEASE
For: Physicians & Nurses. Lecture, June 25, 11:00 AM, Chgo. **CME Credit:** 1 hr., AMA Cat. 1, 2 hrs., AAFP. **Sponsor, contact:** Medical Staff of Martha Washington Hosp., 4055 North Western Ave., Chgo 60618. **Co-sponsor:** Searle Laboratories.

ACIDOSIS AND ALKALOSIS
For: MDs, Discussion/Lecture/Discussion, June 20: Bethesda Hosp., Chgo., 10:00 AM; Lincolnwood Hyatt House, Lincolnwood, IL, 6:00 PM; June 21: Forkosh Memorial Hosp., Chgo. 10:00 AM. **CME Credit:** 5 hrs., AMA Cat. 1. **Fee:** $10. **Sponsor, contact:** Neil Glass, Bethesda Hosp., 2451 W. Howard St., Chgo. 60645.

EVALUATION & MANAGEMENT OF CARDIO-PULMONARY EMERGENCIES
For: GP, FP & Internists. Symposium, June 27-28, Lexington, KY. **CME Credit:** 9 hrs., AAFP. **Fee:** $75. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

HYPERTENSION 1975
For: GP, FP & Internists. Symposium, June 26, Lexington, KY. **CME Credit:** 5½ hrs., AAFP. **Fee:** $20. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

Internal Medicine

ADVANCES IN INTERNAL MEDICINE
For: Internists, 4-Day Wkshp.-Course, June 3-6, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 28 hrs., AMA Cat. 1. AAFP Elective, AOA Elective. **Fee:** $150. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

Obstretics & Gynecology

SPECIALTY REVIEW COURSE IN OBSTETRICS & GYNECOLOGY
For: Ob-Gyn, 10½ day Course, June 2-13, Chgo. **CME Credit:** 86 hrs., AMA Cat. 1. **Fee:** $350. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pediatrics

NEUROMUSCULAR AND LEARNING DISORDERS IN CHILDREN
For: MDs, 5-Day Course, June 9-13, Chgo. **CME Credit:** 27 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

Pulmonary Disease

PULMONARY DISEASE WORKSHOP
For: Family MDs, 2-Day Wkshp.-Course, June 11-12, 8:00-5:00, Ann Arbor, Mich. **CME Credit:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** 14 hrs., AMA Cat. 1, AAFP Elective, AOA Elective. **Fee:** $80. **Sponsor, contact:** R. K. Richards, Dir/Off. of Intramural Ed., Towsley Cntr., U of M, Ann Arbor, MI 48104.

Quality of Medical Care

THE ROLE OF THE HOSPITAL TRUSTEE IN CONTROLLING THE QUALITY OF MEDICAL CARE
For: Hosp. Administrators, Trustees, Physicians. 1½-day Course, June 23: 8:30—5:00; June 24: 8:30—1:00, Sheraton-Chicago, Chgo 60611. **CME Credit:** 17 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** AM. College of Hosp. Administrators, 840 Lake Shore Dr., Chgo. 60611. Attn.: W. Ranieri, Dir. of Ed.

Surgery

MANAGEMENT OF TUMORS OF HEAD AND NECK
For: Surgeons, 5-Day Course, June 9-13, Chgo. **CME Credit:** 35 hrs., AMA Cat. 1. **Fee:** $200. **Sponsor, contact:** Ck. Cnty. Grad. Sch./Med., 707 S. Wood St., Chgo. 60612.

SURGERY REVIEW
For: General Surgeons, General Internists, GP & FP. Symposium, June 1-5, Lexington, KY. **CME Credit:** 25½ hrs., AAFP. **Fee:** $175. **Sponsor, contact:** U.K.M.C., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

July, 1975

Dermatology, Pulmonary Function, etc.

REGIONAL POSTGRADUATE CONTINUING MEDICAL EDUCATION PROGRAM
For: GP, FP, IM, Surg. 2/Day Lecture/Seminar, July 26-27, 9:00 AM-5:00 PM, Radisson Hotel, Minneapolis, Minn. **CME Credit:** 6 hrs., AMA Cat. 1, 12 hrs., Basic and Advanced Life Support-Cardiopulmonary Resuscitation, Cat. 1. **Fee:** $60/course—(includes Brkfst. & Lunch; 8 courses offered). **Sponsor, contact:** American Medical Assoc., Dept. of Scientific Assembly, 535 N. Dearborn St., Chicago 60610.

Family Medicine

FAMILY PRACTICE REVIEW—PART II
For: All MDs. 3-Day Wkshp., July 8-10, Stouffer's Inn, Indianapolis, IN. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** J. L. Roscoe, Program Coordinator, Postgrad. Med. Education, Indiana U. Sch./Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

General Medicine

GENERAL MEDICINE LECTURE SERIES
For: House Staff & Gen. Staff, Lecture Series, July 8, 15, 22, 29. Chgo. **CME Credit:** 18 hrs., AAFP Elective. **Sponsor, contact:** A. Sapienza, MD, Dir/Med. Ed., St. Mary of Nazareth Hosp. Cntr., 1120 N. Leavitt St., Chgo. 60622.

PSRO

PSRO IMPLICATIONS FOR HOSPITAL MANAGEMENT
For: Administrators & Physicians, etc. 2½-day Course, July 21-23, Carson's Nordic Hills, Chicago. **CME Credit:** 18½ hrs., AMA Cat. 1. **Fee:** $225 for affiliates of ACHA; $275 for nonaffiliates. **Sponsor, contact:** Am College of Hosp. Administrators, 840 N. Lake Shore Dr., Chgo. 60611, Attn.: W. Raneri, Dir. of Ed.

August, 1975

Family Medicine

SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE
For: MDs. 10 ½ day-course, August 18-29, Chgo. **CME Credit:** 98 hrs., AMA Cat. 1. **Fee:** $325. Cook County Grad. Schl./Med., 707 S. Wood St., Chgo. 60612.

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Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

BLOOMINGTON — General Practitioners urgently needed. Guaranteed salary with percentage of the business done. Excellent opportunity for energetic young physicians. For further information contact—P. G. Theobald, M.D., President, Theobald Medical Center, #1 Medical Hills Drive, Bloomington, 61701. (9)

BOLINGBROOK—28,000 population, fast growing. Fastest growing community in the state. Short on Professional services, particularly physicians and dentists. 30 miles from Chiago Loop, conveniently located at the intersection of I-55 and Rt. 53. Openings for Family Medicine, Internist, Surgeon, OB-GYN in new Professional Building. Occupancy April-May 1975. Contact: James Pontoriero, M.D., (312) 739-5121. (9)

BROOKFIELD: Going practice - population 24,000. 17 miles southwest of Chicago. Complete office facilities. Considering retirement. Contact: Dr. C. F. Hubner, 8922 Fairview Ave., Brookfield, 60513, (312) 485-6660. (8)

CARMI: Unusually attractive opportunity. Join three Family Physicians in southern Illinois community with drawing population of 18,000. Office adjacent to fully accredited Family Physician Hospital. Guaranteed income of $36,000 first year. Early partnership. Must investigate to appreciate. Call collect days: 618-382-8303; evenings: 618-382-4008. (8)

CARROLLTON: Ample excellent opportunities in Greene County for Family physician. Group practice being set up in new office accommodating 4-5 M.D.'s next to hospital. For further information contact: Dr. Caselton, or Dr. Chung or Roy Shoemaker, 800 School Street, Carrollton 62016 (217-942-6946) (9)

CHICAGO: Established Medical Center, near west side, needs Family Practitioner, patient load 20-30 daily. Lab and EKG on hand. X-ray facilities available. Podiatrist, Optometrist and Pharmacy present. Must have Illinois license and insurance. Contact: Mr. Thomas Gajewicz, Jane Addams Medical Center, 1345 W. Taylor Street, Chicago, 60646 (312-942-0476). (8)

CHICAGO: If you are interested in a 37½ hour week with **no** night calls and salary commensurate, private practice, counting expenses, and willing to enjoy a national reputation in approximately 2 years, call or write Charles Hild, Professional Recruiter, State of Illinois, 160 North LaSalle, Chicago, 60601, 312-793-3866. (8)

CHICAGO: Instant practice—no cost to you—no fees —not an agency. Beautiful new offices. All staff, equipment, furnishings, supplies and administrative services provided. Loop and numerous other locations now available. Excellent hours and benefits. Contact: Master Medical Group, 2400 E. Devon, Des Plaines 60018 (312-298-3500) (7)

DECATUR: Emergency Physicians—work two out of five weeks. Under 55, good health, excellent command of English required. Back ground in GP and/or Surgery desirable. Some teaching involved. Established incorporate group on fee for service. Contact with 400 bed hospital—Emergency Department with excellent profit and pension benefits. CONTACT: DECA Ltd., 2300 N. Edward, Decatur 62526 (217-877-8121) (6)

DANVILLE: Population 42,600. Interest in friendly small community with cultural and metropolitan advantages of larger cities? Interested in practicing in the new ED with plenty of interesting and challenging work? Interested in excellent salary plus fringe benefits? Full-time position available. CONTACT: A. J. Evans, Administrator, Lake View Memorial Hospital, Danville 61832 (217-443-5345) (6)

GALENA: Pop. 4,500. Family/General Practitioner wanted to join three other FPs in county seat town. Complete office facilities adjacent to new 32-bed hospital and 34-bed skilled nursing care facility. Fifteen miles from city of 65,000. This historically rich community nestled in the Galena river valley and hillside offers a very good school system, numerous churches, outstanding recreational facilities (golf courses, ski lodge, swimming pool, tennis courts, fishing, boating and water skiing). Contact Dr. W. E. Johnson, 300 Summit St., Galena, 61036 - Tel. (815) 777-0900. (9)

JOLIET: 1 hour from Chicago. Very rewarding practice available. Owner retiring. Sacrificed for less than half. Best for any speciality, solo or group. Tremendous opportunity. Contact: Dr. P. Bagossy, 500 Western Ave., Joliet 60435 (815-722-1161) (7)

McHENRY: Immediate openings for two full time physicians to augment present Emergency Service Department. Should be experienced in acute care but also sensitive to the needs of all primary care patients. Illinois license required. Hospital is a designated Trauma Center located 50 miles northwest of Chicago. The community offers modern schools, shopping facilities, and recreational areas. Flexible work schedules, competitive salaries, and malpractice insurance coverage. Send resume to: A. Corcoran, McHenry Hospital, 3516 W. Waukegan Rd., McHenry 60050 (7)

MURPHYSBORO: Population 10,000. Wanted FP and OB-GYN to associate with 3-man group: 1 surgeon, 1 FP, 1 internist. Six miles from S.I.U. Good schools. Beautiful lakes for recreation. Good fringe benefits. Contact Medical Arts Clinic, Ltd., W. J. Borgsmiller, President. 215 N. 14th, Murphysboro, 62966. (618) 684-2172. (9)

VANDALIA: Population 6,000. Family physicians needed. Office space available. Hospital with 100 beds, all services. An excellent school system and all denominations of churches. One hour from St. Louis on the interstate highway. Local lake for boating and fishing, close to the Carlyle Lake. Recreational facilities. Contact: D. H. Rames, M.D., 1029 N. 8th St., Vandalia, 62471 (618-283-3012) or Larry Harrison, Administrator, Fayette County Hospital, Vandalia, 62471 (618-283-1231). (12)

WHITE HALL: Population 3,000. Location midway between St. Louis, Mo. and Springfield, Ill. One physician at present. 30-bed hospital, new nursing home, 80 bed, construction underway increasing to 140 beds. Office facility available. Recreational facilities nearby. Contact: George Stahl, 407 N. Main St. White Hall, 62092, 217-374-2121. (8)

BLUE SHIELD REPORT FOR *Illinois Physicians*

HOW TO RETURN A BLUE SHIELD PAYMENT

When it is necessary to return a Blue Shield check or send a refund by personal check, the following information should be included:

(A) **Return of a Blue Shield Check:**
- (1) Attach the voucher portion of the check, if possible.
- (2) If the voucher cannot be attached, include:
 - (a) Patient's Blue Shield group and subscriber number;
 - (b) Blue Shield case number;
 - (c) Date of service;
 - (d) Blue Shield check number.
- (3) A brief explanation for returning an incorrect payment.

(B) **Refund by Personal Check:**
- (1) Make the check payable to Illinois Medical Service.
- (2) Include:
 - (a) A brief explanation for the refund;
 - (b) Name of the patient;
 - (c) The patient's Blue Shield group and subscriber number;
 - (d) Date of service.

All checks should be mailed to Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Your cooperation is appreciated.

Essential Items on Claim Form: I. Itemization of Fees & Services

With Blue Shield's adoption of a new and faster claims processing system, *itemization of fees and services* by (1) date of service (2) description of each service performed and (3) fee charged for *each service* must be entered on the Blue Shield Physician's Service Report form in submitting claims. When fees and services are not itemized, the claim cannot be processed through the system.

If unusual circumstances are involved and additional space is needed, use the reverse side of the service report for explanations. More information is better than not enough. For a surgical procedure, a copy of the operative report may be attached to the claim form.

When you indicate the *fee for each service,* please also indicate whether or not the patient has paid the fee. This is important so that payment may be made to physicians on the basis of their Usual charges for Blue Shield members with benefits under our Usual and Customary program.

II—Date of Accident Needed on Physician's Service Reports

Most Blue Shield contracts provide benefits for emergency care of accidental injuries which do not require an operative procedure such as treatment of sprains, contusions, or abrasions.

To avoid delay in processing, the date of the accident must be shown on the Physician's Service Report.

Blue Cross Benefits for Employees Of General Electric Corporation

Effective May 1, 1975, General Electric employees and their dependents became elegible for hospital benefits under the General Electric Corporation's national Blue Cross program. Payment for hospital services will be made by the Blue Cross Plan for Hospital Care, Hospital Service Corp., 233 North Michigan Ave., Chicago, Illinois 60601. Members enrolled in the program will carry Blue Cross identification cards with the group identified as "GEC", followed by the employee's Social Security number.

General Electric employees *are not* enrolled in the Blue Shield Plan. Therefore, physicians are requested not to submit Physician's Service Report forms to Blue Shield. Please send your request for payment for physicians' services to General Electric Corporation's current insurance carrier. Your patient should have the necessary information.

ASK BLUE SHIELD . . . ABOUT MEDICARE

Medicare Payment for Psychiatric Outpatient Services Limited

Coverage under Part B Medicare includes outpatient psychiatric services, although payment for these services is limited. Regardless of the actual expenses for physicians' services provided in diagnosis and treatment of mental, psychoneurotic or personality disorders of non-hospitalized patients, the recognized limit by Medicare in a calendar year is $500. The maximum Medicare *payment* is $250 over that period, after the deductible of $60 has been met.

Payment of services is based on the 62.5 percent rule applied to the $500 maximum expenses limit ($312.50). Any amount of outpatient psychiatric expenses in excess of this would not be considered in determining benefits. When the allowable charge is below $500, payment is determined by taking 62.5 percent of the charge, less any portion of the unmet deductible, multiplied by 80 percent of the remaining charge.

As an example, a patient had undergone psychiatric treatment from January to August 1974 and incurred total expenses of $600 on an outpatient basis. The benefit payable is computed as follows: $500 is the limit that can be considered for reimbursement. This amount is multiplied by 62.5 percent to arrive at the $312.50 figure determined above. The patient had not, during the calendar year, met any part of the Part B Medicare deductible. Therefore, the $60 deductible is subtracted from $312.50, leaving $252.50. The Medicare payment is $202 (80 percent of $252.50).

Medicare specifies that the limitation is applicable to services furnished in a physician's office, the patient's home, an extended care or similarly approved facility, as well as any items or supplies furnished by the physician in his own office. No distinction is made between the services of psychiatrists or non-psychiatrist physicians.

There is no psychiatric limitation on inpatient psychiatric services. These are paid on the basis of 80 percent of the allowable charge after meeting the $60 deductible for services provided during the year.

SSA Changes in Lab Certifications

The Social Security Administration has certified the following laboratories for participation in the Medicare program:

Illinois Medical Laboratory, Inc.
1420 North Milwaukee Ave.
Chicago, Illinois 60622
Effective January 10, 1975
Provider Number: 14-8287

Universal Medical Laboratories
4753 North Broadway
Chicago, Illinois 60640
Effective Date: March 13, 1975
Provider Number: 14-8288

The following portable X-Ray services were approved:

Alan P. Mintz, M.D. Portable X-Ray Service
1140 Sheridan Road
Glencoe, Illinois 60022
Effective Date: December 10, 1974
Provider Number: 14-9811

Uptown X-Ray Laboratory
4753 North Broadway, Rm. 422
Chicago, Illinois 60640
Effective Date: September 16, 1974
Provider Number: 14-9810

The laboratories listed below have changed their location. The new addresses are:

South Suburban Medical Laboratory
2800 West 87th Street
Chicago, Illinois 60652
Provider Number: 14-8176

Fomaro Clinical Laboratory
4118 West Lawrence Ave.
Chicago, Illinois 60630
Provider Number: 14-8276

North Kimball Medical Laboratory
4470 North Lincoln Avenue
Chicago, Illinois 60647
Provider Number: 14-8137

The following laboratories are no longer certified under the Medicare program:

Lawless P.B. Clinical Laboratory
4305A South King Drive
Chicago, Illinois 60653
Effective Date: March 8, 1975
Provider Number: 14-8284

Mason-Barron Laboratories
1525 E. 53rd Street
Chicago, Illinois 60615
Effective Date: May 5, 1975
Provider Number: 14-8257

(This report is a service to the physicians of Illinois)

IMJ

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Editorials



Figures Lie, and Liars Figure

I always hesitate writing an editorial about an editorial but one that appeared in the October 1974 issue of *American Family Physician* was too good to pass up.

Many government bodies base their reports on "facts" that have been manipulated to prove their point. Results of a small or sample study are obtained and projected on a nationwide scale. Simply, if there are five cases of diphtheria in one square block and the city has 20 blocks, it is easy to *guesstimate* that 100 cases exist within the township. When this old trick encompasses a nation, the results are astonishing and the outcome terrifying if the original facts are not applicable or are not checked or verified before they are put on the 6 o'clock news.

A good example was mentioned in the October issue of *AFP*. The Senate Health Subcommittee was told that between 60,000 and 140,000 Americans die annually of adverse drug reactions. This startling bit of information was picked up and given widespread publicity by the news media.

No one mentioned where these figures came from. Two studies, one done at the University of Florida; the other, in Boston, were the source. The three-year Florida study showed 11 drug-related deaths among patients in medical wards. Seven of whom were being treated for life-threatening diseases.

The Boston study showed 27 drug-related deaths; again, among gravely ill patients with life-threatening diseases. And all might have died if some form of effective drug therapy had not been employed. Nine in the Boston group and seven in the Florida group were receiving highly toxic anti-cancer drugs or other drugs that carry a narrow margin of safety. Nine of the 27 Boston patients were receiving replacement substances to correct fluid and chemical imbalances.

Ostensibly, this represented a typical sampling of hospitalized patients receiving medication. Some clever statistician then projected the 38 deaths to include the nation's total hospital population (32 million a year). And on this basis, the estimate of 140,000 deaths was made. No one, including the reporters, tried to pin down the origin of the report, the type of patient, or the kinds of medicines being used. But since doctors were responsible for the data, it was newsworthy.

T. R. Van Dellen, M.D.
Editor

"Antiacid" action for ulcer patients...

one of the many things you need in an anticholinergic.



Pro-Banthine is considered adjunctive in total peptic ulcer therapy that may include diet, conventional antacids, bed rest, and other supportive measure

Pro-Banthine is provided in several different dosage forms which will meet virtually any clinical need. It is just as versatile in filling patient needs, among which are:

"Antiacid" action—Pro-Banthine® (propantheline bromide) reduces gastr secretory volume and resting total and free acid.

"Analgesic" action—Pro-Banthine help to control the acid-spasm-pain complex

Vigorous anticholinergic action—Pro-Banthine® Vials, 30 mg., are for intramuscular or intravenous use when prompt and vigorous anticholinergic action is required.

Mild anticholinergic action—Pro-Banthine® Half Strength, 7.5 mg. tablets, for more exact adjustment of maintenance dosage in mild to moderate gastrointestinal disorders.

Pro-Banthine
(propantheline bromide)

a good option in peptic ulcer



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propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted. Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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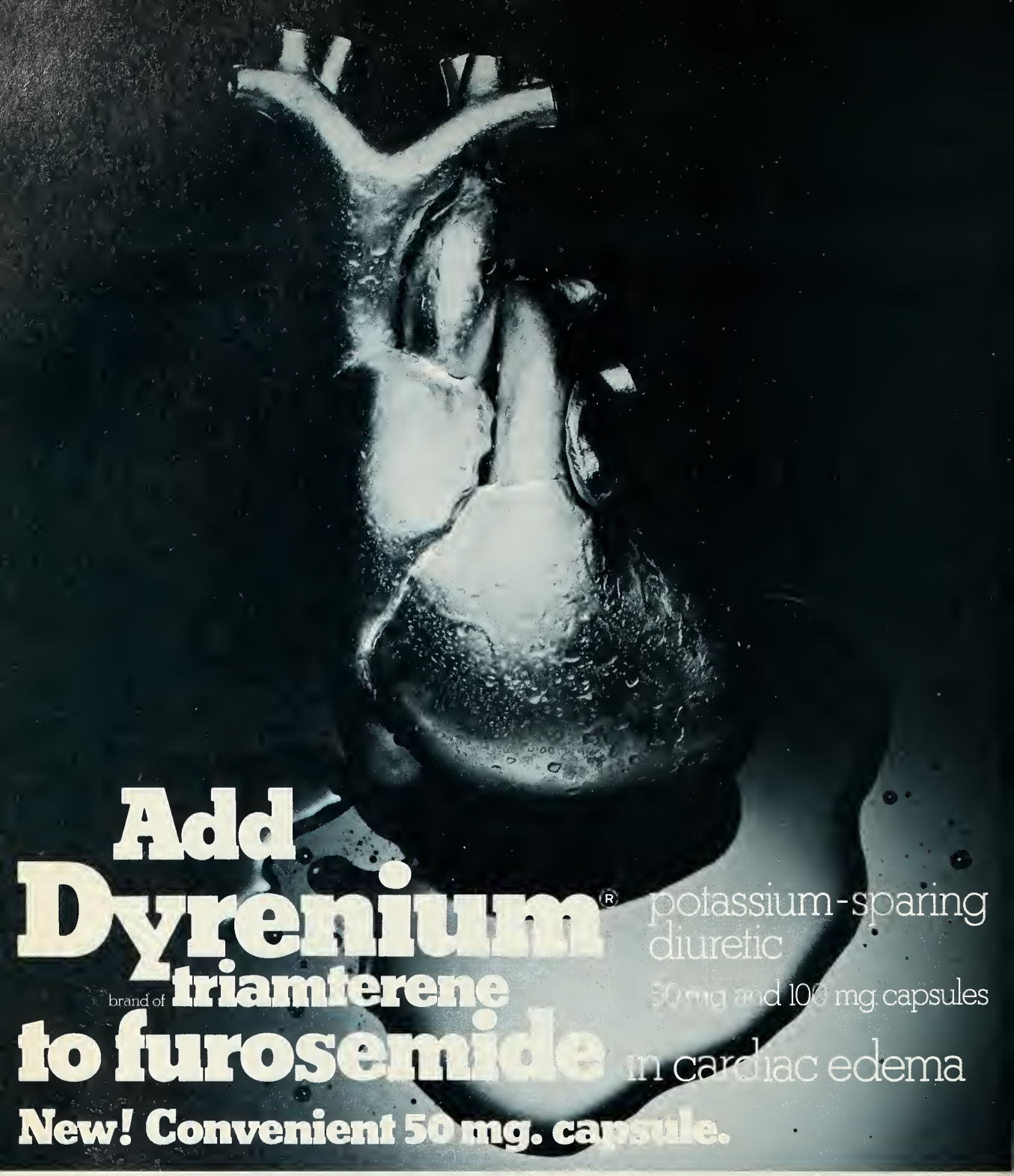
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Clinics for Crippled Children Listed for July

Twenty-eight clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The Division will count twenty-one general clinics providing diagnostic orthopedic, pediatric, speech and hearing examination along with medical, social and nursing services. There will be six special clinics for children with cardiac conditions, and one for children with cerebral palsy. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

July 1 Belleville, St. Elizabeth's Hospital
July 2 Springfield Pediatric Neurology, Diocesan Center
July 2 Hinsdale, Hinsdale Sanitarium
July 3 Sterling, Sterling Community Hospital
July 3 Effingham, St. Anthony Memorial
July 3 Lake County Cardiac, Victory Memorial Hospital
July 8 E. St. Louis, Christian Welfare Hospital
July 8 Peoria, St. Francis Children's Hospital
July 9 Champaign-Urbana, McKinley Hospital
July 9 Joliet, St. Joseph's Hospital
July 10 DuQuoin, First Methodist Church
July 10 Macomb, McDonough District Hospital
July 10 Springfield, St. John's Hospital
July 11 Chicago Heights Cardiac, St. James Hospital
July 14 Peoria Cardiac, St. Francis Children's Hospital
July 15 Rock Island, Moline Public Hospital
July 15 Quincy, Blessing Hospital
July 15 Decatur, Decatur Memorial Hospital
July 17 Elmhurst Cardiac, Memorial Hospital of DuPage County
July 22 Peoria, St. Francis Children's Hospital
July 23 Rockford, St. Anthony Hospital
July 23 Centralia, St. Mary's Hospital
July 23 Chicago Heights, St. James Hospital
July 23 Elgin, Sherman Hospital
July 24 Rockford, Rockford Memorial Hospital
July 25 Chicago Heights Cardiac, St. James Hospital
July 28 Peoria Cardiac, St. Francis Children's Hospital
July 29 E. St. Louis, Christian Welfare Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse association, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases the work of the Division is intended to extend and supplement, not supplant activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.



"First dose" natriuretic effect of concomitant 'Dyrenium' (50 or 100 mg.) and furosemide (40 mg.) was up to four times as great as that of furosemide (40 mg.) alone, compared to baseline values, in 10 normal volunteers.[1] 'Dyrenium' (50 or 100 mg.) blocked the kaliuretic effect of furosemide in 7 subjects. Patients with fluid overload and abnormal physiology may respond differently from volunteers; therapy should be titrated to the individual.

1. Stote, et al.: Effect of Triamterene on Furosemide Induced Kaliuresis in Normal Volunteers, J. Int. Med. Res. 2:379-83, 1974.

Hyperkalemia can occur with any K^+-sparing agent, but it is rare if urinary output is adequate. Serum K^+ and BUN should be checked periodically; elderly, diabetics, or patient with suspected or confirmed renal insufficiency should be observed closely. When 'Dyrenium' is given with furosemide K^+ supplements should be discontinued, and not given unless hypokalemia develops or dietary potassium intake is markedly impaired.

See facing page for indications and brief summary of prescribing information.

Dyrenium®

brand of **triamterene**

Potassium-sparing adjunct to furosemide in cardiac edema.

Now in 50 mg. and 100 mg. capsules.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Edema associated with congestive heart failure, cirrhosis and nephrotic syndrome; steroid-induced edema, idiopathic edema, edema due to secondary hyperaldosteronism and edema resistant to other diuretic therapy.

Contraindications: Severe or progressive kidney disease or dysfunction (possible exception: nephrosis). Severe hepatic disease. Pre-existing elevated serum potassium. Hypersensitivity to the drug. Continued use in developing hyperkalemia. Do not give potassium supplements, either by drug or by diet.

Warnings: Observe regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported. Check BUN and serum potassium periodically, especially in the elderly, diabetics, and those with suspected or confirmed renal insufficiency. Use in pregnancy only when essential to patient welfare.

Dyrenium (triamterene, SK&F) and spironolactone are not usually used concurrently, if they are, however, frequent serum potassium determinations are required.

Precautions: If hyperkalemia develops, withdraw the drug. The following may also occur: electrolyte imbalance, low-salt syndrome (with low salt intake), reversible mild nitrogen retention, decreasing alkali reserve with possible metabolic acidosis. Do periodic hematologic studies in cirrhotics with splenomegaly. Concomitant use with antihypertensive drugs may result in an additive hypotensive effect. When 'Dyrenium' is to be discontinued after intensive or prolonged therapy, withdraw gradually because of possible rebound kaliuresis.

Adverse Reactions: Diarrhea, nausea and vomiting (may indicate electrolyte imbalance), other gastrointestinal disturbances, weakness, headache, dry mouth, anaphylaxis, photosensitivity, elevated uric acid, rash.

Note: When combined with another diuretic, the initial dosage of each agent should be lower than recommended.

Supplied: 50 mg. capsules, in bottles of 100; 100 mg. capsules in bottles of 100, in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630

Subsidiary of SmithKline Corporation

Obituaries

*Bezdek, Joseph, Texas, died Jan. 27 at the age of 74. Dr. Bezdek graduated from Chicago Medical School in 1935.

*Blaha, George, Chicago, died March 15, at the age of 62. Dr. Blaha graduated from the University of Illinois in 1939.

*Blackwell, Joseph, Evanston, died April 8, at the age of 64. He graduated from Northwestern University in 1936.

**Brosiloff, Florence, Chicago, died April 8, at the age of 83. She graduated from Stritch Medical School in 1918.

*Brundza, Frank, Round Lake, died April 21 at the age of 64. Dr. Brundza graduated from Loyola University Medical School in 1940. He was a past president of the American Academy of Family Physicians and on the staff of St. Theresa and Victory Memorial hospitals in Waukegan.

**Czachorski, John, Chicago, died April 1, at the age of 85. He graduated from Loyola Medical School in 1914. Dr. Czachorski was a founder of South Chicago Community Hospital.

*Corrigan, Marion, Chicago, died Feb. 21, at the age of 74. Dr. Corrigan specialized in pathology at Michael Reese Hospital for 25 years. She graduated from Rush Medical in 1931.

*Cutter, William, Pekin, died March 21 at the age of 58. Dr. Cutter graduated from Northwestern University in 1942.

**Fowler, Earle, River Forest, died March 23 at the age of 90. He graduated from Rush Medical School in 1910. Dr. Fowler specialized in opthalmology for over 50 years.

*Lerner, David, Chicago, died March 16 at the age of 67. He graduated from the University of Illinois in 1932.

**McGrath, Floyd, Evanston, died March 19 at the age of 80. He graduated from the University of Illinois in 1924. Dr. McGrath was on the staff of St. Francis Hospital for 50 years.

*Sippel, Raymond, Chicago, died March 25 at the age of 67. He graduated from Stritch Medical School in 1938.

*Taylor, Willison, Canton, died Feb. 22 at the age of 60. He graduated from the University of Illinois in 1951. Dr. Taylor was past president of the Fulton County Medical Society.

**Indicates ISMS member*
***Indicates ISMS member and member of the Fifty Year Club*

Must vasodilators and therapy for other diseases come into conflict?



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Vasodilan is not incompatible with any of these drugs—no treatment conflict has been reported. And, unlike other vasodilators, Vasodilan has not been reported to affect carbohydrate metabolism, liver function, or intraocular pressure—or to complicate treatment of diabetes, hypertension, peptic ulcer, glaucoma, or liver disease.

In fact, there are no known contraindications to the use of Vasodilan in recommended oral doses, other than that it should not be given in the presence of frank arterial bleeding or immediately postpartum.

1. Gertler, M. M., et al.: Geriatrics *25*:134-148 (May) 1970.

Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

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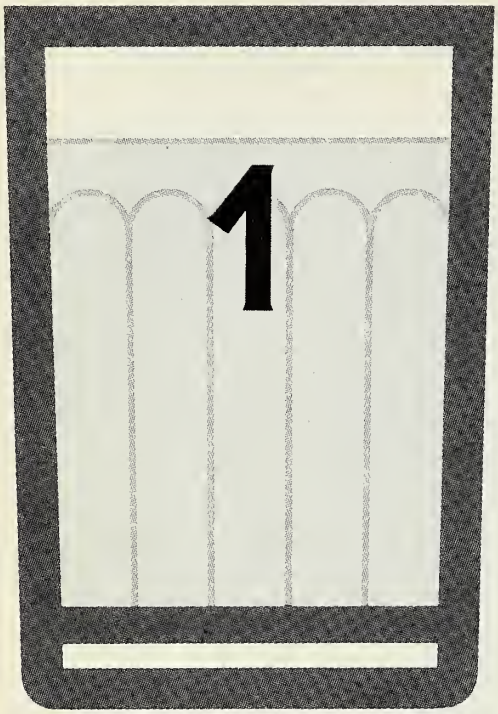
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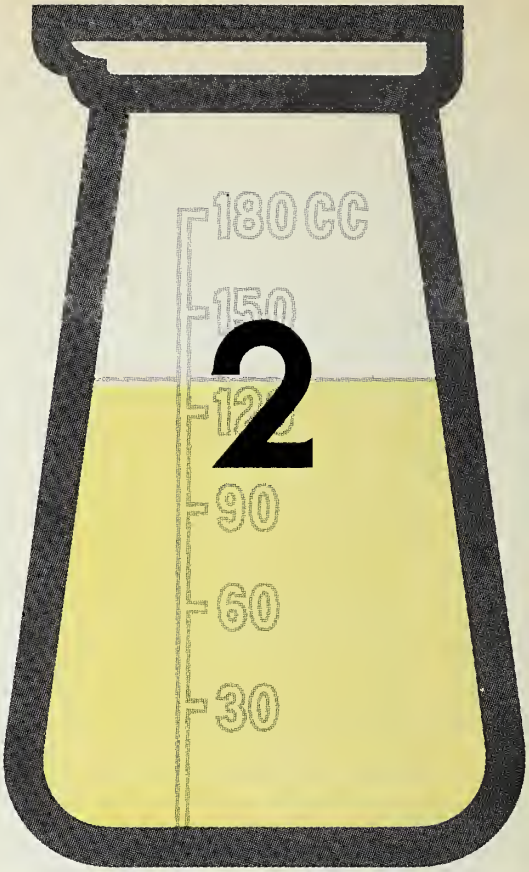
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References: 1. Reuter, S.H., and Montgomery, W.W.: Arch. Otolaryng. *80*:214-217 (Aug.) 1964. **2.** Osol, A., et al., ed.: The United States Dispensatory and Physicians' Pharmacology, ed. 26, Philadelphia, J.B. Lippincott Co., 1967, p. 171. **3.** Schwartz, A.D., and Pearson, H.A.: J. Pediat. *78*:558-560 (March) 1971.

Precautions and Adverse Reactions: If a rare sensitivity reaction occurs, the drug should be stopped. Acetaminophen has rarely been found to produce any side effects.

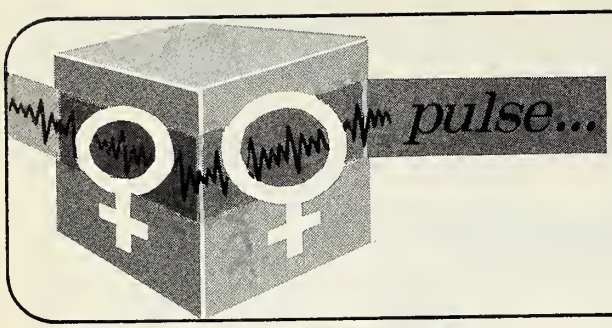
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Drops, 60 mg./0.6cc. (alcohol 7%).
Chewable Tablets, 120 mg.

Safer than aspirin, yet just as effective for relief of pain and fever

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acetaminophen products

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pulse... of the doctor's wife

Mrs. Harold Keegan, Editor



Mrs. Eugene Vickery

Millie is from Lena, Illinois and has been very active in the auxiliary on all levels. Millie and her husband, a General Practitioner, are the parents of four children.

The new president in her installation address stated that her theme for the year would be "Patchwork" to symbolize the auxiliary's activities in our country's bicentennial year.

In patchwork, every pattern starts with one piece, joined to another and YOU are needed to join with others in your auxiliary to work together for friendship and caring. Then extend the patchwork into the community and so on. See your patchwork quilt grow-Don't forget to "Focus on Family" this year.

At the luncheon each of us received a little "Patchwork Bag" called a "Blessing Bag" in which you place a penny when you are counting your blessings.

Mrs. Vickery stated in conclusion "Participate, Be a Good Finder and Count your Blessings! Put together an Auxiliary Patchwork—large or small—but make it beautiful and meaningful—and enjoy doing it!"

***Sincere apologies** to Mrs. Thomas P. Meirink of Belleville who designed and made the needlepoint emblem of the Auxiliary which she presented to Mrs. Thomas Glatter at the Annual Convention. In the May IMJ, Mrs. Joseph Santiago was incorrectly indicated as the designer of the needlepoint.*



Mrs. John W. Ovitz

Mrs. John W. Ovitz was installed as President-Elect of the ISMS Auxiliary at the 47th Annual Meeting. Jane and her husband, who is in family practice, are the parents of five children. Jane, a former laboratory technician, has continued her interest in medicine as the wife of a physician. She is a member of the DeKalb County Auxiliary and has served the Auxiliary in many capacities both on the county and state level.

You will be seeing a lot of Jane this year as she plans and attends the district meetings.

Dates to Note

September 24, 1975—Fall Meeting of the Board of Directors, (County Presidents invited) Ramada Inn, Springfield, Illinois.

September 25, 1975—Patchwork Symposium (all members invited) Ramada Inn, Springfield, Illinois.

November 12, 1975—ISMS and ISMS Auxiliary Conference - Chicago, Illinois. "Cultural Looking Glass"

March 28-31, 1976—ISMS Convention, Conrad Hilton Hotel, Chicago, Illinois.

AMA Auxiliary Convention Atlantic City — June 15 to 18th

The 1975 annual convention of the AMA Women's Auxiliary (June 15-18) will for the first time feature a combination of business sessions and educational programs.

The convention will launch a new venture for the Auxiliary—joint programming with the AMA Council on Scientific Assembly.

Highlighting the joint scientific programming will be the luncheon on June 17, "Science and Ideals in a Hungry World." Featured in a panel discussion will be Rene Dubos, professor emeritus of the Rockefeller University of New York City, and Mona Doyle, director of consumer affairs for Food Fair Stores, Inc.

Other scientific programs will include "Estate Planning for Physicians and Their Families," prepared by the American Law Institute, Philadelphia, and a session on "Sexual Enrichment."

Featured speakers will be Malcolm Todd, M.D., AMA President, who will give the keynote address on Monday; George Plimpton, author and TV personality, who will speak at the annual luncheon honoring national past-presidents and honorary members; and Mary Louise Smith, Republican National Committee Chairman, who will speak during the Tuesday morning business session.

More on the convention at a later date.

Convention Notes

The following motions were submitted and approved by the House of Delegates at the convention.

Motion #1

I move that the Illinois State Medical Auxiliary take an active stand against the continuing adverse exposure of our youth to violent television programs, "lurid sex and pornography," and, that our Illinois Delegation to the National Convention express our stand on this problem and urge the adoption of a similar concern at the National level.

Motion #2

I move that we ask our Federal Congressional Legislators to draft legislation allowing for the creation of a continuous warning symbol to be seen in a corner of the television screen while any potentially objectionable program is being televised, (as opposed to the single warning at the beginning of such programs).

Motion #3

I move that we ask our Congressional Representatives to find a way to delay the 7 pm network programs in order for them to run at 8 pm in the Central Time Zone along with the rest of the country. "This includes major network programs of lurid sex, pornography and violence."

Delegates and Alternates to WA/AMA

Mrs. Eugene Vickery
(Presidential Delegate)
Mrs. Thomas Glatter
(Delegate)
Mrs. Earl Klaren
(Delegate)
Mrs. Sherman Arnold
(Delegate)
Mrs. Edward Szewczyk
(Delegate)
Mrs. August Martinucci
(Delegate)
Mrs. Eugene Leonard
(Delegate)
Mrs. Joseph O'Donnell
(Delegate)
Mrs. John Ovitz Jr.
(Delegate)
Mrs. Harold Keegan
(Delegate)
Mrs. H. Frank Holman
(Alternate)
Mrs. Mitchell Spellberg
(Alternate)
Mrs. Clifford Nyman
(Alternate)
Mrs. John Koenig
(Alternate)
Mrs. John Ring
(Alternate)
Mrs. Robert Johnson
(Alternate)
Mrs. Henry Schorr
(Alternate)
Mrs. Wilson West
(Alternate)

Measuring cause and effect

Cause: High levels of anxiety
Effect: Exacerbation of irritable bowel syndrome



hen barium fills the whole colon, there also a reflux through the ileum so that um is superimposed on colonic shadows. ne tube-type descending colon revealed normally associated with the diarrheal ase of the irritable bowel syndrome.

Case History:* 27-year-old female

Before treatment

Chief Complaint: Abdominal pain and diarrhea.

Present Illness: Intermittent, left-sided, lower abdominal pain for over a year; pain, unassociated with menstrual periods or eating, lasted several hours. Abdominal symptoms occurred in attacks lasting 1-2 days with remissions of 3-4 days. Diarrhea accompanied attacks. No weight loss, nausea or vomiting.

Personal History: Married, 2 children. Somewhat restless, tense and anxious.

Physical Examination: 8/16/73. System review within normal limits. Weight 95 lbs. Petite, pleasant, cooperative patient with no obvious signs of illness.

Abdomen: Spastic, tender sigmoid colon. Otherwise normal.

Rectal: Normal mucosa and stool. No rectal bleeding or excess mucus or fat in stools.

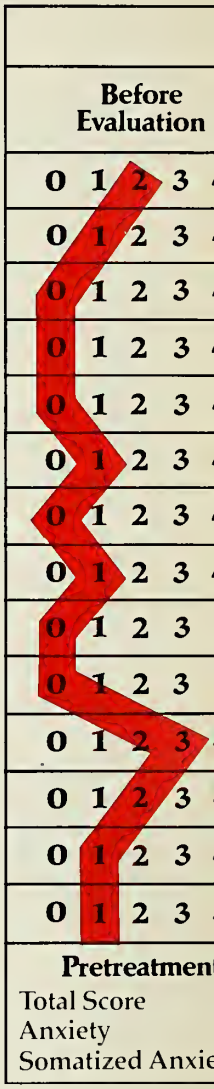
Sigmoidoscopy: Normal sigmoid mucosa.

Laboratory tests: Within normal range. No occult blood in 3 successive stool examinations.

Impression: Irritable bowel syndrome. X-rays 7/25/73 showed tube-type descending colon. Librax, one capsule *q.i.d.*, prescribed as adjunctive therapy on 8/23/73. Symptoms of anxiety evaluated with Hamilton Anxiety Scale on same date.

*Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J. 07110.

Although this is an actual case history, not all cases of irritable bowel syndrome can be expected to respond this rapidly to therapy.



Undue anxiety—often a forerunner of irritable bowel syndrome

rritable colon is a disorder commonly seen in the verage physician's daily practice. Expressed as diarhea and/or constipation, the disorder affects mainly ne colon's tonicity. Usually spasms are produced, nediated through the autonomic nervous system. uch abnormal activity can easily derive from emoional stress, which causes parasympathetic stimulaion. Hence the direct relationship between anxiety nd irritable bowel syndrome. Reducing anxiety, one of the causative factors, can be expected to counter the effect, exacerbation of irritable bowel syndrome.

Librax is the logical adjunct in treating irritable bowel syndrome

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ISMS Guide to Continuing Medical Education

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

WARNING! Items for this Calendar come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in date, place or time occur too late to be corrected before publication. You are urged to contact the sponsoring organization to confirm information given below.

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July, 1975

Dermatology, Pulmonary Function, etc.

REGIONAL POSTGRADUATE CONTINUING MEDICAL EDUCATION PROGRAM
For: GP, FP, IM, Surg. 2/Day Lecture/Seminar, July 26-27, 9:00 AM-5:00 PM, Radisson Hotel, Minneapolis, Minn. **CME Credit:** 6 hrs., AMA Cat. 1, 12 hrs., Basic and Advanced Life Support-Cardiopulmonary Resuscitation, Cat. 1. **Fee:** $60/course—(includes Brkfst. & Lunch; 8 courses offered). **Sponsor, contact:** American Medical Assoc., Dept. of Scientific Assembly, 535 N. Dearborn St., Chicago 60610.

Family Medicine

FAMILY PRACTICE REVIEW—PART II
For: All MDs. 3-Day Wkshp., July 8-10, Stouffer's Inn, Indianapolis, IN. **CME Credit:** 26½ hrs., AMA Cat. 1, AAFP. **Fee:** $100. **Sponsor, contact:** J. L. Roscoe, Program Coordinator, Postgrad. Med. Education, Indiana U. Sch./Med., Fesler Hall, 1100 W. Michigan, Indianapolis, IN 46202.

General Medicine

GENERAL MEDICINE LECTURE SERIES
For: House Staff & Gen. Staff, Lecture Series, July 8, 15, 22, 29. Chgo. **CME Credit:** 18 hrs., AAFP Elective. **Sponsor, contact:** A. Sapienza, MD, Dir/Med. Ed., St. Mary of Nazareth Hosp. Cntr., 1120 N. Leavitt St., Chgo. 60622.

PSRO

PSRO IMPLICATIONS FOR HOSPITAL MANAGEMENT
For: Administrators & Physicians, etc. 2½-day Course, July 21-23, Carson's Nordio Hills, Chicago. **CME Credit:** 18½ hrs., AMA Cat. 1. **Fee:** $225 for affiliates of ACHA; $275 for nonaffiliates. **Sponsor, contact:** Am College of Hosp. Administrators, 840 N. Lake Shore Dr., Chgo. 60611, Attn.: W. Raneri, Dir. of Ed.

The AMA 1975 Clinical Session

This year's meeting in Hawaii —November 30 to December 5— features 29 CME courses, including "Birth Defects & Clinical Monitoring," "Infectious Diseases in Children," and "Practical Endocrinology"—plus the usual wide array of general sessions on medical topics of current importance. Most courses and sessions meet 7:15 AM to Noon, leaving ample time for relaxation in the beautiful island ambience.

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For full information, write to . . .
Illinois Division, Inc.
American Cancer Society
37 South Wabash Avenue
Chicago, IL 60603

August, 1975

Family Medicine

SPECIALTY REVIEW COURSE FOR FAMILY PRACTICE
For: MDs. 10 ½ day-course, August 18-29, Chgo. **CME Credit:** 98 hrs., AMA Cat. 1. **Fee:** $325. Cook County Grad. Schl./Med., 707 S. Wood St., Chgo. 60612.

September, 1975

Cancer

THIRD ANNUAL CHICAGO SYMPOSIUM—NEOPLASM IMMUNITY: MECHANISMS
For: Oncologists, Surgeons, Internists, Hematologists. Two-day conference, Sept. 11-12, Blackstone Hotel, Chicago. **Credit:** 10 hrs. AMA Category 2. **Sponsor, contact:** Ray G. Crispen, M.D., Institute/TB Research, U/Illinois, 904 W. Adams, Chicago 60607.

Medicine

UPDATE ON ANTIBIOTICS
For: All physsicians, nurses, paramedics. Seminar, Sept. 23. Speaker, Walter S. Wood, M.D. **Credit:** 1 hr. AMA Category 1. **Sponsor, contact:** John Huss, M.D., Memorial Hospital/DuPage County, Avon & Schiller, Elmhurst 60126.

DERMATOLOGY IN FAMILY PRACTICE
For: All physicians. Visiting Lecturer: A. Schroeter, M.D., Mayo Clinic. Sept. 19: 10 AM, Grand rounds, Forkosh Hosp.; 6:00 PM, lecture, Lincolnwood Hyatt House. Sept. 20: 10 AM Grand rounds, Bethany Methodist Hosp. **Credit:** 5 hrs. AMA Category 1. **Fee,** deadline (for dinner only): $10, Sept. 15. **Sponsor, contact:** Shephard Plotner, FAB^3-CME, Forkosh Hosp., 2544 W. Montrose, Chicago 60618; (312) 267-2200.

Opthalmology

THE EYE IN SYSTEMIC DISEASE
For: Physicians, nurses. Lecture, Sept. 24, 1975. **Speaker:** Howard Reinglass, M.D. **Credit:** 1 hr. AMA Category 1; 2 hrs. AAFP elective. **Sponsor, contact:** Fernando Lopez-Fernandez, M.D., Martha Washington Hospital, 4055 N. Western, Chicago 60618.

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IMJ
Illinois Medical Journal
Vol. 147, No. 6, June, 1975

Use of "G" Suit* in Treatment of Acute Massive Upper Gastrointestinal Hemorrhage

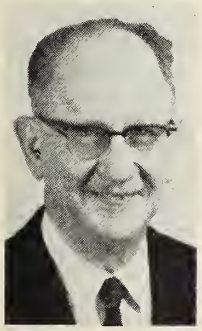
By George Milles, M.D./Sycamore and E. E. Carlson, M.D./Genoa

Sudden hypovolemic hypotension demands correction. Intravenous volume replacement has been the therapy of choice by many physicians in spite of the possibility that it contributes to the bleeding.[1] *Gardner's circumferential pneumatic compression by means of a "G" suit*[2-5] *for the control of hypovolemic hypotension due to massive upper gastrointestinal hemorrhage has been used successfully but not widely publicized.*[6]

The sudden drop in blood pressure with the attendant clinical symptoms in two hospitalized patients offered another opportunity to evaluate the "G" suit in the management of this clinical problem.

Case Reports: Case I

W.J., W/M was found to be suffering from diabetes incidental to a phlegmon of the neck at age 54. A year later he was hospitalized for treatment of a fracture dislocation of his ankle. At this time his blood pressure was 200/104, RBC 4.9, Hb 15.9, Ht. 46, WBC 8.3, blood sugar 219.



GEORGE MILLES, M.D., received his medical degree from the University af Illinais Callege of Medicine. He is an Internist in Sycamare, presently semi-retired.



ELBERT E. CARLSON, M.D., received his medical degree from the University of Illinois and is a General Practitioner in Genoa, primarily interested in internal medicine.

*"G" suit furnished by Dr. William O. Elson, The Kendall Co.

Four years later he fainted, fell and fractured his humerus. Prior to this incident he had been taking antacids. His stools were black and contained 2 plus occult blood (hematest). "Duodenitis" was diagnosed by X-ray. Hb. 12.9, Hb. 40, BP 180/90. The fracture was immobilized, he was placed on ulcer management and was discharged on the 5th hospital day.

Two weeks later he again noted that his stools were black. This was followed in three days by passage of a voluminous black stool and he collapsed. His physician described him as pale and cold with a thready, rapid pulse, BP 60/40, and fully conscious. When hospitalized, within two hours of onset, temp. 99.6, P 140 and thready. BP 72/48 rose to 92/56 within an hour after admission while normal saline was running I.V.

He was given a total of 1000 ml. whole blood and 1500 N/S during his first seven hours in the hospital. At the end of this period his BP was 120/66 and pulse 80-90. His vital signs remained stable during the following 48 hours while he received 4000 ml. N/S. The I.V. was discontinued. Oral feedings had been started on HD2. The admission RBC of 2.3, Hb. 7.3, Ht. 22 rose

to RBC 2.5, Hb. 8.8, Ht. 25. On HD6 Hb. was 7.9, Ht. 24. A unit of blood was given on this day. The blood pressure was stable until HD8 when it was 98/78. It dropped precipitously to 68/40 on HD9. The "G" suit was applied. The blood pressure quickly rose to 110/64. On this day Hb. 7.8 and 6.0, Ht. 24 and 18. Twelve hours later the "G" suit was removed because of complaints of discomfort. The pressure hovered in the 90's/50's. The following day Hb. 5.5. When discharged on HD15 Hb. was 6.0, Ht. 20. The hospital course was complicated by a urinary tract infection about HD8. His hematocrit rose slowly to low normal during the following two months.

Case II

E.S., a 54 year old minister had only minor episodes of heart-burn prior to a sudden upper gastrointestinal hemorrhage. He was hospitalized about 36 hours after its onset. Admission Hb. 6.3, Ht. 20, BP 122/52. About four hours after admission he had a projectile emesis of about 800 ml. of blood. An hour after vomiting BP was 114/64, P 112 and he developed vertigo when his back rest was elevated to about 10°. About four hours later, BP had dropped to 96/40, P 120 and he became extremely weak. A Foley catheter was inserted, padding was placed between his legs to avoid the distressing pressure on the opposed legs, and the "G" suit was applied with the equivalent of 20 mm. of Hg. pressure. The BP rose at once to 126/60 though the pulse remained at 120. The BP remained stable during the subsequent 12 hours. The "G" suit was then removed after slowly reducing its pressure. He was now able to sit upright without discomfort within the following six hours.

Hb. gradually dropped to 4.4 and Ht. 15 on HD4, five days after the initial hemorrhage. Treatment consisted of frequent feedings, antacids and iron supplement. Nothing was given I.V. At the time of discharge ten days after admission Hb. 5.9, Ht. 19, and the stool contained a trace of blood. A duodenal ulcer was identified by X-ray on the 3d hospital day. He had replaced his lost erythrocytes two months after the hemorrhage.

Discussion

Maintenance of the blood pressure at a functional level depends on the total blood volume, the capacity of the vascular bed and the force applied to the blood by the heart. Hypovolemia is corrected spontaneously by moving extravascular fluid into the intra-vascular space, a process that requires time. Progress of the volume repletion can be followed by measuring the blood volume or indirectly by observing the dilution effect of the increasing intra-vascular fluid as evidenced by the falling hemoglobin concentration and the decreasing number of red blood cells per unit of blood or their decreasing percent of the blood volume in the hematocrit. Severe anemia can be tolerated; acute, prolonged hypotension can have serious consequences.

The response of the two patients suggests that Gardner's circumferential pneumatic compression promptly corrects the hypotension of hemorrhagic hypovolemia, following a massive upper gastrointestinal hemorrhage. This conclusion has been substantiated by the observations of others.[6] One of the patients (E.S.) received no intravenous fluid replacement but was given oral feedings and antacids as soon as he would eat.

Three precautions must be observed in applying the "G" suit:

1. Place a 3″ or 4″ sponge rubber pad between the legs to prevent the discomfort caused by the pressure of the opposing legs on each other.
2. Insert a Foley catheter so that the pressure may be maintained for prolonged periods.
3. Do not raise the pressure above the equivalent of 20 mm of mercury as indicated on the water monometer of the "G" suit.

Summary

Application of Gardner's circumferential pressure "G" suit quickly stabilized the hypotension incidental to massive upper gastrointestinal hemorrhage in two patients. The one patient was given blood and intravenous fluids. The other was fed orally and given antacids but received nothing by vein. Both had an uneventful recovery and ultimately repleted their lost red blood cells. ◄

References

1. George Milles, M.D., Charles J. Koucky, M.D., H. Gale Zacheis, B.S.: "Experimental uncontrolled arterial hemorrhage," *Surg,* Vol. 60, No. 2, pp 434-442, August, 1966.
2. W. James Gardner, M.D., and Donald F. Dohn, M.D.: "The antigravity suit (G-suit) in surgery," *JAMA,* Vol. 162, Sept. 22, 1956.
3. W. James Gardner, M.D.: "Circumferential pneumatic compression-effect of the 'G-Splint' on blood flow," *JAMA,* Vol. 196, pp 491-493, May 9, 1966.
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Sickle Cell Anemia Services: Do Physicians and Laymen Agree?

By James E. Walker, Ed.D./Alabama

Sickle cell anemia is a condition caused by abnormal hemoglobin in the blood cells and is restricted almost exclusively to persons of African descent. It is an inherited condition and manifests itself by pain in the abdomen, legs, and arms, and by swelling of the joints. Within the last year or two, a great deal of attention has been focused on the condition. This recent upsurge in interest and publicity has led many persons to think of sickle cell anemia as a very recent medical discovery. In fact, sickle cell anemia is believed to have originated in Africa and the Mediterranean areas centuries ago and was introduced into America in 1619, when black slaves reached the shores of Virginia.[1]

According to Scott,[2] educating the public at large on the problem of sickle cell anemia is one of the major problems confronting the Black community at this time. Although the medical profession has been the profession most directly concerned with sickle cell anemia, it has not been successful in adequately educating the public about sickle cell anemia. This failure to disseminate sufficiently information about sickle cell anemia may be in part due to a tendency in the medical profession to use a language which is not easily understood by the layman.[3] Francis, Wether, and Fenwick[4] have alluded to the fact that the dissemination of information about sickle cell anemia has three main objectives:

1. Informing the public at large about sickle cell anemia.
2. Informing potential sicklers of the availability of sickle cell anemia diagnostic facilities.
3. Informing sicklers or parents of sicklers of the short and long term effects of sickle cell anemia.

With regard to the first point, informing the public about the nature of sickle cell anemia, only a small percentage of Blacks have heard of sickle cell anemia, and even a smaller percentage know that it is a blood condition.[5]

The second objective is informing potential sicklers of the availability of sickle cell anemia diagnostic facilities. In the past, most sickle cell anemia diagnosis has been conducted by private physicians and laboratories for those patients who could afford it. Now, in most major cities (Atlanta, Chicago, Detroit, New York, Philadelphia, Washington, D.C.) there is at least one hospital which provides sickle cell tests. However, very little consideration has been given to the possibility that community health agencies, public school health facilities, community welfare facilities, may prove to be more economical and may reach greater numbers of people than present diagnostic facilities.

The third and final objective is informing sicklers or parents of sicklers of the short and long term effects of sickle cell anemia. The problem of explaining sickle cell anemia to sicklers or parents of sicklers has one shortcoming, viz., the only time the explanation sessions are usually initiated is after an offspring has been diagnosed as having the condition. Due to the recessiveness of the trait in most sicklers, and the lack of adequate diagnosing procedures; most parents are not aware of the need for counseling.[6]

Problem

To date, professionals involved with sickle cell anemia have not had a comprehensive model or plan to assist them in effectively and efficiently disseminating information about sickle cell anemia to the target audiences. The majority of the literature published on sickle cell anemia has been printed in professional journals and in a language which usually cannot be understood by laymen. There is a limited amount of information being transferred to the public at large about sickle cell anemia. Procedures for dissemination of information have taken six basic forms: (1) pamphlets, (2) booklets, (3) magazines, (4) films, (5) radio and television, and (6) by "word-of-mouth."

Francis, Wether, and Fenwick[4] alluded to the fact that there is no evidence that any of these

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methods is clearly superior to any of the others in reaching the public. Furthermore, there does not seem to be any evidence that the methods of disseminating information used by the disseminators are, in fact, the methods that are preferred by the intended receivers of the information. If a dissonance exists between disseminators and receivers, then a different means of public dissemination must be employed. Therefore, it seemed feasible to collect evidence which would assist in the development of guidelines for the disseminating of information about sickle cell anemia to the public. A procedure of this nature should not only prove to be useful with sickle cells anemia; but might also be utilized with diseases such as diabetes, cystic fibrosis, or muscular dystrophy. The problem then, was to study the various common methods for dissemination of information about sickle cell anemia and to compare the preferences of disseminators and receivers for various information dissemination plans.

Population

The target audiences for information about sickle cell anemia were two related groups: 100 Black citicens (the Black public at large who may or may not have sickle cell anemia and 34 parents of sicklers. Parents of sicklers refer to those individuals with children who have been diagnosed as having sickle cell anemia or trait. These two groups were located in Philadelphia, Pennsylvania. In this study these subjects will be referred to as receivers of information.

Disseminators of information about sickle cell anemia represent a very different population. In general, disseminators were 28 physicians actively involved in diagnosis of sickle cell anemia and 8 agencies or organizations whose primary concerns are such activities as lobbying on behalf of sickle cell anemia, recruiting professionals to work in the area, or disseminating information about sickle cell anemia.

Instrument

The instruments used to gather data for this study were a questionnaire and a structured interview form. An identical set of questions were used on the instruments; the only difference was the method of administration. Data from receivers were obtained by asking questions of them verbally. The same questions were asked of the disseminators by means of a printed questionnaire. Since the questions were identical, the two separate formats were regarded as a single instrument.

Results and Discussion

The purpose of this study was to compare receivers and disseminators of information about sickle cell anemia with regard to their attitudes toward certain components of a sickle cell information program. It was hypothesized that there would be no differences between the responses of disseminators and receivers to questions related to the following topics:

a) informing the public about sickle cell anemia,
b) diagnostic facilities,
c) explaining sickle cell anemia to sicklers,
d) the school and sickle cell anemia.

A questionnaire developed by the investigator was used to collect data for the study. The questionnaire consisted of 15 specific research questions, each of which was directly related to one of the four topics listed above. Questionnaire data were collected from 134 receivers of information (100 Black citizens and 34 parents of sicklers) and 36 disseminators of information (28 physicians and 8 organizations working in the area of sickle cell anemia).

With regard to informing the public, it was concluded that the receivers and disseminators were in agreement about the most preferred ways of informing the public. The only significant discrepancy between the receivers and disseminators was that the receivers believed that Black Superstars should be used to inform the public about sickle cell anemia and the disseminators believed that physicians should be asked.

There were no disagreements between the receivers and the disseminators on the questions related to diagnostic facilities. It was concluded that both groups were in close agreement as to the desired type and hours of operation of diagnostic facilities.

It was concluded that the receivers and disseminators were in close agreement on most of their responses to the four questions related to the procedures for explaining the long and short range effects of sickle cell anemia to sicklers. In general, they agreed that it would be desirable for a physician to meet individually with patients in the patient's home to explain the consequences of the disease.

It was concluded that receivers and disseminators shared similar views relating to the school and sickle cell anemia. Disseminators and receivers were in close agreement that the public schools should play a major role in informing children about sickle cell anemia and should provide a screening service for the children.

Based on the results of this study, a set of guidelines for the establishment of sickle cell information programs was developed. These guidelines encompass the major findings and conclusions of this study and may be helpful to persons attempting to set up sickle cell information programs.

Guidelines for the Establishment of Sickle Cell Information Programs

The guidelines presented here were formulated as a result of this study and should be helpful to persons attempting to establish sickle cell information programs. The guidelines are grouped under the four main headings (hypotheses) which have been used as the organizational schema for the study.

Informing the Public

1. The preferred means of informing the public about sickle cell anemia are radio and television broadcasts. If radio and television coverage is not possible, then newspaper and magazine displays may be used. Obviously, the use of several different media, and similar media with diverse target groups, should result in a higher proportion of persons receiving sickle cell anemia information than if only a single means of information dissemination were used.

2. Information about sickle cell anemia should be presented by Black superstars, physicians, or ministers. In general, these persons are believed to have high status in the Black community and thereby to have a certain credibility that other persons might not have.

3. The most important kinds of information to present about sickle cell anemia are:

a) It is an inherited, abnormal blood condition.
b) It is not contagious.
c) There is no known cure.
d) Tests for the condition can be easily and quickly given.

If information is disseminated through Black oriented media, it is not necessary to indicate that the condition is almost exclusively restricted to persons of African descent.

Diagnostic Facilities

1. The most desirable facilities for the administration of sickle cell screening and follow-up tests are physicians' offices, mobile sickle cell clinics, and welfare agencies. Hospitals are not considered desirable.

2. Although certain simple tests such as Sickle-Dex are suitable for screening persons, the electrophoresis test should be used to determine whether or not a given individual actually has sickle cell anemia or sickle cell trait.

3. The most desired times for visiting sickle cell diagnostic facilities are weekday mornings and Saturdays. Evenings and Sundays are not as desirable.

Explaining Sickle Cell Anemia to Sicklers

1. If a given person is diagnosed as having sickle cell anemia or sickle cell trait, efforts should be made to explain to him the consequences of his condition.

2. Individuals with sickle cell trait may find it necessary from time to time to seek professional help concerning their conditions. This professional help may be best provided by medical doctors.

3. Individuals with sickle cell anemia will not only need the initial explanation of the disease, but continuous counseling and medical care.

4. Explanations of the conditions can be made either to individuals or to small groups. The most desirable place for such meetings is in the patient's home. Slightly less desirable locations are doctors' offices and hospitals.

5. The most desirable person to provide explanations about sickle cell conditions and to provide genetic counseling are physicians. Nurses and social workers are also considered acceptable for this task provided they have the necessary training in genetic counseling.

The School and Sickle Cell Anemia

1. Efforts should be made to establish comprehensive screening programs within the public schools. School children should be screened for sickle cell anemia just as they are screening for vision and hearing problems.

2. Information about sickle cell anemia should be presented as a special topic in schools. It could also be included as a unit of study for classes in hygiene, sex education, science, or social studies. School nurses and social workers are considered the most desirable persons to present this information.

3. Special school programs about sickle cell anemia should be provided in the elementary schools or junior high schools.

4. School nurses and social workers should be aware of the identities of sicklers in their schools and should be prepared to take immediate action if a sickle cell crises occurs. In the absence of the

(Continued on page 541)

Carcinoma Within Bladder Diverticula

By Prospero Sanidad, M.D., Harry L. Miller, M.D., and
J. Y. Lee, M.D./Bronx, N.Y.

The number of new or singular cases discovered is next to none so that when a so-called rare case comes about, one is compelled to review the records. More often than not, one is astonished at the number of reports that have already preceded the case at hand. As the saying goes, nothing is new except that which has been forgotten. We report an instance of a malignant neoplasm arising within a vesical diverticulum.

Case Report**

On May 28th, 1971, a seventy year old male started to notice passage of gravel through his urine and at that time, also noted a weight loss of about seven pounds. He consulted a urologist who noted an enlarged distended bladder and the patient was admitted for evaluation June 10th, 1971, twelve days after onset. Past history was not contributory. Physical examination revealed a conscious, active, well-developed and well nourished patient with normal TPR. The head, neck and thorax were negative. The only salient physical finding was a mass (more of a density) in the pelvis and lower abdomen arising five fingers' breadth above the symphysis which was interpreted as a full bladder. There were no nodes or edema. Salient laboratory data included urinalysis showing traces of protein and a positive culture sensitive to most antibiotics. Cystoscopy showed moderate amounts of blood in the bladder. The orifice of a diverticulum was seen in the right posterior bladder wall. The contents of the diverticulum were not visible.



Figure 1. Scout film of the abdomen showing a stellate calculus believed to be in the bladder.

X-Ray Findings

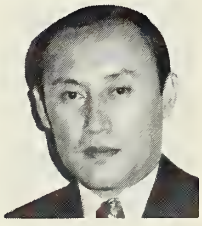
The scout abdomen (Fig. 1) showed a stellate calculus in the bladder. Intravenous Pyelographic studies (Fig. 2) showed a diverticulum which was suggestively larger than the bladder but neither was opacified well enough for complete evaluation. However, a subsequent cytogram (Fig. 3a and 3b) revealed the diverticulum to contain filling defects and a differential diagnosis of debris, hemorrhage or tumor masses within the diverticulum was forwarded.



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**Acknowledgement is made to Dr. Abraham Orron, the Bronx-Lebanon Hospital Center, for the use of his case.*

Surgery was performed one day after admission. Operative findings showed the bladder was filled with blood. The diverticulum with its ostium in the posterior bladder wall was noted and removed; its contents were not visible. Postoperative diagnosis: bladder diverticulum containing clotted blood. Benign prostatic hypertrophy. The patient was transferred from the operating room in fair condition.

Pathologic Findings

Fragmented specimens were received. Gross and microscopic:

A. Fragments of necrotizing and differentiated carcinoma.
B. Fragments of largely undifferentiated carcinoma with patchy squamous differentiation and keratin formation.
C. Bladder wall with mucosal inflammation and areas of acute necrotizing cystitis.
D. Calculus.

The immediate postoperative course was unremarkable except for a slight increase in temperature, the cause of which could not be determined by consequent workup studies. Chemo and radiotherapy were contemplated but abandoned when the patient's course took a downward direction by the third day. The patient expired July 17th, fifty one days after onset of symptoms. No autopsy was performed.

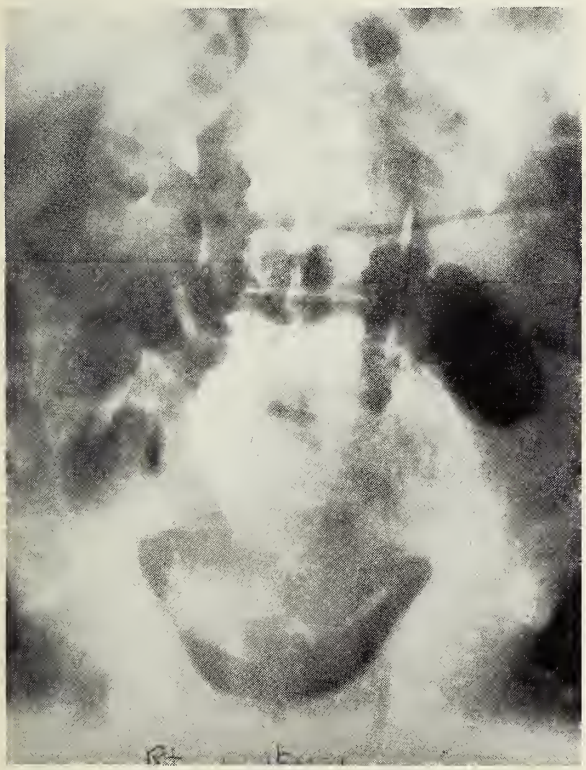


Figure 2. Intravenous pyelogram demonstrating a diverticulum which appears to be larger than the bladder.

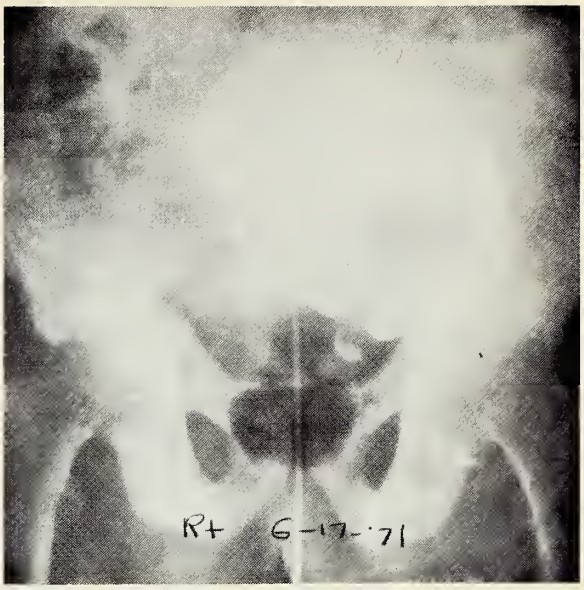


Figure 3a. AP and right oblique cystograms revealing filling defects within the bladder diverticulum.

Discussion

Historically, the first reference to a neoplasm in a diverticulum was in an autopsy report on a sixty-two year old male who died in Middlesex Hospital, London in 1882. This was in a report entitled "Sarcoma of a Diverticulum of a Bladder" by Williams, Boylan and McDonald.[1] In the light of studies on carcinoma imitating sarcoma, this tumor was more probably a carcinoma. Of greater interest, is the information on the earliest recognition of diverticula in the bladder by Albucasis, eight centuries earlier and of the first introduction of the forerunner of the modern cystoscope by Nitze in 1806. In 1926 Clyde Leroy Demming[2] in a report of a case of his, mentions an earlier one in 1909 by Dr. Hugh Young.[3] In 1912 Targett[4] forwarded three cases in London and in 1925, Judd and Scholl[5] reported four carcinomata within 133 cases of bladder diverticula, so that as early as 1927, already ten cases were on records, nine of whom died. All were males and eight were in their seventies.

The number of reports increased periodically. Some were scattered single cases. The largest series were by Abeshouse and Goldstein[6] of the Sinai Hospital, Baltimore who, in 1943, reported 44 cases; 25 cases by Boylan, Green and McDonald[1] of the Mayo Clinic; and in 1960, from the Squier Urological Clinic, New York, a series of 18 cases reported by Knappenberger, Uson and Melicow,[7] in which they gleaned their cases from



Figure 3b. AP and right oblique cystograms revealing filling defects within the bladder diverticulum.

the files dating 1932 through 1957. By 1960, the total number of cases in the English literature was less than 200 in ninety years. However, the fact that most of these cases were discovered in a retrospective study of the files indicates that primary carcinoma in vesical diverticula probably occurs more frequently than the literature indicates. From the non-English speaking literature, two cases from Argentina, (Derdoy et al 1967,[8] Rochman, 1968[9]) and one from Poland (Fryczkowski and Panicz[10]) are included in this retrospect. We present our case not so much to add to this total, but as a reason for reviewing this condition.

Incidence

The rate of occurrence of primary carcinoma occurring in a diverticulum ranges from 2.9%[6] to 4%.[7]

Age and Sex

Almost all the patients were in the age range from the fourth to the seventh decades of life, the youngest being forty (Blum[11]) and the oldest, an 83 year old male reported by Clancy[12] in 1941. Virtually all are males except for one white female reported in The Squier Group.

Symptoms

Hematuria is a predominant symptom lasting from a few days to about eight weeks before admission. Symptoms of prostatism are next in frequency. Other symptoms such as right flank discomfort, loss of weight and periods of priapism have been noted. All these symptoms can occur in varying combinations.

Pathology

Diverticula have a tendency to arise in the points of congenital weakness of the muscular wall. Thusly, most of the cases reviewed were situated close to the ureteral meati or in the posterolateral walls of the bladder. The tumors vary in size from microscopic to the readily-visible. They may be benign or malignant. The majority are transitional cell types with an almost equal distribution from Grade I to IV. A lesser number are of the squamous cell type. The stage of wall penetration is not feasibly determined due to a paucity of muscle elements in the diverticular wall. It is merely stated whether the tumor has extended beyond the lining into the peridiverticular fat or was confined to the surface.

Diagnosis

The diagnosis of diverticula was clinically established in 50 to 60% of the cases. Methods employed were cystoscopy, cystodiverticulography and some were discovered at surgery for removal of the diverticula or for relief of the obstructing prostate. A few were discovered by the pathologist. In October 1965, Shawdon et al[13] at the Hammersmith Hospital, London, described a double contrast cystography. This involved introduction of Steripaque into the bladder, then evacuation and subsequent replacement by carbon dioxide.[13] Intravenous pyelographic studies show that despite propinquity of the diverticulum to the ureter, not all develop obstruction. As an incidental observation the prognosis for patients with malignant neoplasm in a diverticulum with ipsilateral ureteral obstruction is uniformly grave. By retrograde cystography, evidence of a tumor in a diverticulum presents as incomplete filling and/or irregular contour of the diverticulum, progressive, and finally complete occlusion of the diverticulum.

Treatment

When deemed inoperable due to extent, mere palliation is attempted. This is directed towards control of hemorrhage, urine deflection, radiotherapy and the use of supportive regimen. Those considered amenable to surgery are submitted to either suprapubic cystotomy with simple diverticulectomy or segmental resection of the bladder portion which includes the diverticulum.

Prognosis

Survival is more directly a result of the degree of anaplasia and has no relation to the type of surgical approach. Death occurs from one month to two years in Grades III to IV cases whereas, a minority of cases in the Grade I to II group reportedly survive up to three years. Followup has not been available. One would, therefore, conclude that patients with Grade III to IV tumors die within two years, whereas a better prognosis is noted in the tumors of Grade I and II.

Summary

It now appears in summary that primary neoplasms within diverticula occur not too rarely. As the papers from the Mayo Clinic, Sinai Hospital and Squier Clinic indicate, it occurs more than the existing literature indicates, their cases being from files of two to three decades earlier and which had never been reported. Conceivably, more cases exist that are not on record. The incidence, as culled from literature, is from 2.9 to 4%. The number of tumors within diverticula has been found to exceed the number of bladder tumors lying outside of a coexistent diverticulum. Therefore, whenever a diverticulum and a tumor coexist, more than likely the tumor will be within the diverticulum. It then behooves one to scrutinize every diverticulum as a potential site of neoplastic growth. For the record, this condition, but for a negligible number of females, may be stated as a disease of males from forty to seventy.

There is no classic symptom complex but hematuria and prostatism are present in the majority. With the demonstration of a diverticulum, any bleeding must be viewed with alarm. A diverticulum that remains filled with contrast material after the bladder has emptied must also be suspected. As advised by Spence and Baird,[14] diverticulectomy is advisable as a primary procedure when retention is demonstrated, irrespective of site. Our one added case proves to be typical, being a seventy-year old male with a high grade carcinoma within a bladder diverticulum and who expired about eight weeks after onset of symptoms. ◄

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Sickle Cell Anemia

(Continued from page 537)

nurse or social worker, the child's teacher or principal should be prepared to give the child immediate assistance in the event of a crisis.

Summary

The purpose of this study was to compare receivers and disseminators of information about sickle cell anemia with regard to their attitudes toward certain components of a sickle cell information program. It was hypothesized that there would be no differences between the responses of disseminators and receivers to questions related to the following topics: (a) informing the public about sickle cell anemia; (b) diagnostic facilities; (c) explaining sickle cell anemia to sicklers; (d) the school and sickle cell anemia.

Based on the results of the study, a set of guidelines for the establishment of sickle cell information programs was developed. These guidelines encompass the major findings and conclusions of the study and may be helpful to persons attempting to set up sickle cell information programs.

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Mid Forceps Delivery With Uterine Rupture (Inadvertent Hysterotomy?)

By Thomas W. McElin, M.D., M.S. and David R. Claypool, M.D./Evanston

A 27-year-old gravida III, para 0, aborta II (each, mid-trimester), EDC 8/27/70, was submitted to a McDonald-Hofmeister procedure at eighteen weeks gestation (3/28/70) because 2.0 cms. of cervical dilatation had been achieved in the week subsequent to the last weekly examination. The patient was hospitalized for four day periods on two occasions in May, 1970 because of scant vaginal bleeding without uterine contractions and discharged on 5/28/70 with a closed cervix.

A third admission was necessitated 5/31/70 (28 weeks gestation) after the onset of "gushing" vaginal bleeding. Examination revealed a closed cervix, vertex presentation, −2 station, FHT of 160, normal maternal vital signs. There were no uterine contractions.

Four hours after admission repeat vaginal examination revealed bulging membranes protruding in hour-glass fashion through a minimally dilated cervix. "Prophylactic" intravenous administration of alcohol was begun. The situation remained unchanged for 36 hours when five minute uterine contractions began despite a continuing alcohol infusion. Vaginal bleeding at the rate of one pad per two hours shortly ensued. After 16 hours of what seemed to be modest contractions despite the continuing administration of intravenous alcohol, the cervix appeared to be 6 cms. dilated. The fetal heart rate was normal.

Approximately 45 minutes later under spinal anesthesia, the membranes were artifically ruptured when the cervix was "completely" dilated and an easy mid-forceps delivery of a two pound, five ounce male infant (Apgar 7) was accomplished over a mid-line episiotomy. The placenta delivered spontaneously and manual exploration revealed an intact uterus. The cervix was inspected and the external os was found to be intact! A vertical tear (profusely bleeding) was discovered in the cervix extending from immediately above the intact cerclage suture to the apex of the vagina (12 o'clock position). The apex of the laceration was easily identified and the cervical-lower segment laceration was repaired. 500 c.c. of whole blood was administered.

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The mother was discharged in good condition on the sixth postpartum day and the infant was discharged in good condition on 8/15/70 (74 days after birth) weighing five pounds and four ounces. The child was in excellent health in April, 1975.

How should the delivery of this infant be classified? A cesarean section is defined as the delivery of an infant by means of incisions in the abdominal and uterine walls.[1] Incision of the uterus, hysterotomy, is the essence of the operation. A vaginal hysterotomy (or "vaginal cesarean section"—which is an obvious misnomer) is defined as a longitudinal incision through the cervical os and cervix into the lower uterine[2] segment (with bladder elevation) to facilitate delivery of the uterine contents. Colporrhexis (vaginal laceration) and annular or circular detachment of the cervix are terms descriptive of specific genital trauma which we must recognize but which are not relevant to this situation.

We feel it inappropriate to state that we delivered this infant by vaginal hysterotomy because this would indicate a deliberate incision through the external cervical os. Delivery clearly occurred through a laceration—a uterine rupture (could we label this an inadvertent[3] hysterotomy?) in that portion of the cervix above the intact (sutured) external os. We choose, therefore, to classify this bizarre situation which eventuated in a happy outcome as an instance of successful mid forceps delivery with uterine rupture. We would be pleased to consider alternative nomenclature or classification. ◄

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Considerations in Prolonging Life—A Dying and Recovery Score

Part I

By Vincent J. Collins, M.D./Chicago

Death is defined in simplistic terms and is divided into clinical death and biological death. Dying is described as a progressive process, with each organ deteriorating at a different rate. Clinical death is the cessation of integrative action between all organ systems of the body. A multiparameter scoring system assists the physician in defining irreversible coma. It is used in determining when efforts at resuscitation should be abandoned yet when biological life of organs continues. The score helps to quantitate also the stages of recovery from coma and anesthesia.

Phenomenal technological and scientific advances in medical science make it possible to prolong threatened life to an incredible degree and to make a composite man by the transplantation of organs. An essential question arises at times, as to whether or not we are dealing with true human life.

When the vital functions are maintained, the integrity of the brain and of other organs, at their particular capacity at that moment, can be sustained and functional recovery will likely occur and a rational human being can be restored. At times, the vital organs are irreparably damaged by injury or disease and recovery or reanimation to a spontaneous level is impossible. Although we may be able to use extraordinary means to sustain the biological activities of organs and provide the semblance of existence, an integrated, spontaneously existing, rational man may be unattainable.

These considerations have prompted re-examination of the ethics of medical practice. There exist apparent contradictions and dilemmas in the medical, moral and the legal area. An initial question is what is new about our problems? Or do we have adequate guides or principles to solve the problems of medicine or society? Perhaps what is most new is our assumption that the problems are new. Actually, only the appearances of the problems are new. The circumstances are, indeed, complicated by our science and by our machines, but the guides to their solution are still elemental, sound and true.

The Dilemmas

A dilemma in the area of medical practice concerns the recognition of life on the one hand and the decision to conclusively diagnose death on the other. Guided by the ethical principle inherent in the Hippocratic oath is the doctor's obligation to both benefit his patient and at the same time do no harm. Adherence to the two parts of this oath is often the principle dilemma. To relieve suffering by appropriate drugs or procedures may be a threat to life. Many procedures which aim to preserve life may increase suffering. The terminally ill patient requires careful assessment of dying. When is it justified to withhold or to discontinue therapy in such patients? This is a revealing rhetorical question which has a clear answer: When the therapy is ineffective and without benefit! Note that one must distinguish between the terminally ill patient who is requiring "intense care" and extraordinary measures, who is in the final phases of the dying process, and a patient with a terminal illness or disease who at some later date will be in the final phases of the dying process.

The dilemma of death is summarized in two questions. First, at what moment is it right to pronounce a patient clinically dead, without hope of reanimation to a full human life with a meaningful existence, if at the same time the individual organs are biologically alive and potentially useful for transplantations?[1] Secondly, when is it morally right and scientifically correct to remove artificial life supports and to remove organs for transplantation to sustain the life of another?[2] The answers to these questions lie in correct diagnosis of clinical death—yet, to make this decision at a point in time before the biological death process is operational.

The dilemma actually concerns the recognition of life potential versus the need to conclusively diagnose death either at the clinical phase or the biological phase. It is asserted that the solution to the dilemmas faced in prolonging life, delaying death, or of recognizing each is the responsibility of the medical profession. The broad guidelines to making the decision are elemental.

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The Primary Determinants

The basic obligation of the physician is to ensure man's existence as a whole human being with a meaningful life. In confronting the problem of death or of life the physician is challenged by the need for differential diagnoses.

For any course of action there are three determinants. These are: 1) contractural (patient-physician relationship); 2) ethical; and 3) scientific.

Physician-Patient Contract

The crux of medical practice is, of course, the physician-patient relationship. This is a contract with an implicit and explicit relationship. In the physician-patient relationship medical care is implied. The duties of the physician are correlative to those of the patient. The patient expects the services of the physician to be for his benefit, and therefore permits an invasion of his physical and mental privacy. Incumbent on every physician is the obligation that he must exert individual judgement, self-discipline and a conscientious attitude in his decisions regarding another special human being—his patient. He must respect the patient's rights.

The right of privacy is a "natural right" of man. "It is the claim of an individual to determine for himself when, how, and to what extent information about himself is communicated to others."[3] However, this is never absolute. Society also has certain claims. The only absolute authority over our minds or bodies must remain a supernatural one.

One might also state that the right to maintain the privacy of one's personality is part of the right of self-preservation. This right is shared and even surrendered by a patient when he consults a physician. A patient visits a physician to seek advice and help. There is an implied consent for therapy. In this relationship the physician informs the patient of the state of health and the options to maintain health. It is the physician's duty to educate the patient about his condition. This has popularly been designated as informed consent, but is better termed an "educated consent."

Some forms of therapy are implicit. Other more serious complex therapies, such as surgery and anesthesia, may be explicit in a written consent form. Throughout his practice a moral understanding and sensibility to the health problems of the individual must be exercised by the physician. The contractural relationship is and must be one governed by the moral virtue of faith and the doctrine of trust.

Ethical Guides

Since an implicit contract exists between a physician and a patient, we must assess the ethical principles guiding the physician in fulfilling his contract. Every contract has *obligations*. Elements that operate in this personal contract include the patient's faith in the doctor, and the doctor's competence, dependability and expertise; the patient's hope that he will be relieved of his illness and the physician's desire that his efforts will be fruitful; as well as the *love* between patient and physician as neighbors in society. Hippocrates stated this in the Physician's Oath:

> "I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patient, and abstain from whatever is deleterious and wrong. I will give no medicine deadly to anyone, even if asked, nor suggest any such counsel."

Another way of stating the duties of a physician to his patient is according to the Golden Rule, the Universal Rule stated in all religions in various ways. This is a most pertinent guide to regulate human and medical conduct. The words of Christ as they appear in Luke (6:31) state, "As you wish that men would do to you, do so to them."

It is also revealed in the Talmud (Shabbat 31a), "What is hateful to you, do not to your fellow man. That is the Law; all else is commentary."

Medical ethics are part of general ethics. These are rules of conduct established between men and women dealing with the rights of man and what is good and beneficial to the individual and to the community of men. They are exemplified in the duties and in the habits of caring for one's fellow man. Ethics are principles founded in the moral virtue of love.

The fulfillment of our humantarian duties requires a reverence for human life; requires a respect for the sanctity of the body and a recognition of the right to human dignity.

The Scientific Determinant

Based on medical facts and good judgment, the physician does those things in any situation which will benefit his patient. He must do those things which predictably result in improvement of his patient. The techniques of reanimation are proven, sound and legitimate. They can and do prolong life, but it must be determined that the nature of the resultant life is not mere biological

existence of several organs, but totally integrated functional existence at a rational human level.

To continue an act or procedure of therapy which neither produces an improvement nor has the potential to achieve "full human life" is imprudent, illogical and irrational. This is the essence of medical practice. When a physician and his team bring together all the knowledge and skill related to sustaining life processes and treating patients with disease, he does so rationally. The effectiveness of his therapeutic skill must be constantly assessed. In artificially maintaining life or in arresting a disease process, the physician buys time. He provides by his assistance time for the patient's natural recovery processes to act and return the individual to a spontaneous, personal full life.

If, after reasonable time all measures are obviously not effective and are not reversing the dying process, then the measures are failing. Deterioration may be observed. To persist may produce the appearance of life, but it is more often technical or mechanical life. The final decision will then be made in the face of a late phase or a second endpoint, namely, that of biological life. It is the physician's obligation to cease efforts early when they are determined to be ineffective in the total reanimation process and objectives. The patient should then be allowed to die. He has this right; he should not be cheated of a peaceful death in the face of a physician powerless to restore consciousness.

A vegetating patient, hopeless and irresponsive and showing no spontaneous activity, should be allowed to die peacefully, not in pieces. Physicians should make the dying process dignified.

The scientific determinant is founded in the moral principle of hope. Science is one of the intellectual virtues denoted by understanding, knowledge, and wisdom. The patient hopes that his physician will apply these virtues and expects him to show prudence tempered by love and respect in the selection of a course of action. To a large extent in modern medical practice the scientific determinant must also be tempered by distributive justice.

Courses of Action in Treatment

In the unconscious or hopelessly ill patient requiring resuscitation, there are three courses of action:

1. Active Treatment—Prolonged Dying vs. Reanimation.
2. Active Intervention to End Life—Euthanasia.
3. Passive Management—Shortening the Dying Process.

Let us address ourselves to these courses of action.

The first problem that poses a dilemma and requires serious examination is the problem of prolonging life. In reality this is a problem of therapy. Second, and in contrast, is the problem of euthanasia which involves a deliberate decision to actively end life. The prolonging of life or the lengthening of life contrasts with the objective of euthanasia, that is, the shortening of life and the dying process by passive management.

A physician's approach toward the inevitable ending of life may be either passive or active. Death could occur by actively interceding or by passively discontinuing therapy. In the first instance, one directly causes life to end by an overt act; whereas by discontinuing therapy, death is permitted by omission of an act and permitting nature to take its course.

Ordinary and Extraordinary Means

A definition of ordinary and extraordinary means is required. Ordinary measures of patient care are recognized as elements of essential care. They represent obligatory, proven and justified therapies and procedures. They are denoted by the fact that the patient himself can obtain them and put them to his own use. They further represent measures which he can reasonably undergo with only minimal or moderate danger and maximal effectiveness. Such measures are also not an impossible or excessive burden.

Extraordinary measures, on the other hand, are complicated methods. They are impossible for the patient to use or apply to himself and present a costly and difficult burden. In addition, they represent a high level of danger and the results expected are not predictable. The effectiveness is minimal or moderate while the dangers are maximal.

Extraordinary measures sustain life artificially at the level it is found. Hopefully, at this point in time, there is no organic deterioration. The measures in resuscitation may then arrest the lethal process. The aim is to gain time in order for natural restorative processes to operate.

Aspects of Prolonging Life

However, the more complicated question is that of prolonging life. Can we reconcile our scientific decisions to prolong life or let a patient die with our ethics and morality? Yes! But we must continue to clearly distinguish between letting a patient die and euthanasia. The first is mercy dying (not passive euthanasia), the second is mercy killing (murder).

Every physician is liable for his actions, and every action of a physician requires medical judgement. In saving a life, in preventing death,

and in prolonging life, three questions must be asked: Is the condition irreversible and the end result inevitable? Is the life artifically sustained one of mere organic existence (vegetable)? Is death inevitable and can it be medically determined (diagnosed) now?

When one permits death by not continuing therapy, the harm is done by *nature acting*. This is passive management based on reason and the judgement to shorten the act of dying. It is rational. Therapy is discontinued when the efforts to maintain sound life are manifestly ineffective.

Thus, the problem is a challenge in therapy. It is possible for the doctor to artifically support life, at least the traditional vital functions of respiration and circulation. He must know what to do, when to do it and when to stop. In his therapeutic approach, the doctor will employ both simple or ordinary means as well as extraordinary means to support life.

Euthanasia

When one actively intercedes to end life, one is, in fact, causing harm to the individual, even though this harm may apparently have a good reason. Man is acting and this course of action is abhorrent and prohibited.

Another apparent dilemma is that of motives. Behind every good deed is a motive. Motives can be colored. When man is the direct instrument to death, the law has historically related this to his intention. And two intentions are evident, an intention with malice or the intention with mercy. Regardless of the reason, whether malice or mercy, the end is murder.

The withdrawal of ineffective therapy and of special life supports in irreversible coma is not euthanasia—passive or otherwise. It is therapeutic rationalism. This is also the alternative to euthanasia. The only valid argument for euthanasia is the relief of suffering. But this can be accomplished by concerned and appropriate therapy and pain control services. Euthanasia can be characterized by an act of commission which achieves relief by destroying the sufferer. It is non-therapeutic, involves total harm, and is abandonment of the patient. As such it is misguided mercy. The act of killing is the proximate cause of death.

We should now dispose of this question: Shall we perform a deliberate act to positively end a life-that is euthanasia. From the legal standpoint, from the moral codes and from the guidelines of ethical practice, we find applied the general law that no one is permitted to actively kill—regardless of the intent.

Definitions of Life and Death

These dilemmas force us to reassess the standards of practice. The medical profession must confront the problems of death and its present definition, as well as it confronts the problem of understanding life. The challenge is to apply customary human and moral principles to the dilemmas.

In examining the subject of prolonging life (by artificial mechanical means or organ transplantation) the medical profession is faced with the fundamental need and, indeed, an obligation to formulate clearer criteria of life as well as clearer standards of death.

Nature of Life

To identify the nature of human life is the first obligation. Fundamentally, life is the integration of the biological functions of at least nine organ systems.[4] (Table I) The integration of these systems is emphasized. Life is not the mere function of these organs independently, nor is human life represented by the independent simple biological life processes in each organ. Blood cells, organ tissues, and even a whole organ may be maintained alive *in vitro* but such independent existence does not represent a human being.

It is the whole organisms representing the sum of the structural parts, all integrated functionally which establish the existence of life. The integration of all parts by the central nervous system is manifested in the capacity to reason and abstract. This ability identifies human life as against all other forms of life. Thus, by the total integrative process, there emerges a being greater than the parts called man.

TABLE I

Life—Integration of Physiological Functions
Locomotion—Musculoskeletal System
Digestion—Gastrointestinal
Metabolism—All Cells
Excretion—Renal
Endocrine—Glands
Coordination—Nervous System
Respiration—Pulmonary
Circulation—Cardiocirculatory
Reproduction—Genital System

Definition of Death

It is worthwhile that we define death and refer to the kinds of death which in different professional areas may be appropriately identified. Death in its simplest and broadest sense is the irreversible cessation of life functions. There are three forms of death to be recognized: clinical

death, biological or cell death, and theological death.[1] Of importance to our text is clinical death, which is the permanent cessation of integrated life functions.

Biological death refers to the cessation of the simple life processes of organs, tissues and cells. Theological death may designate the time when the soul is not longer present.

The Nature of Dying

Dying is a progressive process. Each part of the body or each organ system deteriorates progressively at different rates. Each organ has a *vulnerability index* and a revival time. Thus, the brain has a high degree of vulnerability to lack of oxygen and/or nutrition. It is more sensitive in this regard than the next most vulnerable organ, namely, the heart. The time during which the brain may recover if restoration of circulation is achieved is approximately 4 minutes.[5] This is a period of relative vulnerability and deterioration. Recovery is probable, but after 4 minutes becomes improbable, and after 8 minutes is usually impossible. The heart can withstand loss of circulation upwards of 8 minutes but thereafter the revival of the heart becomes improbable, if not impossible. The revival period to which we refer is therefore dependent upon several factors: 1) time; 2) temperature; 3) perfusion; 4) oxygen tension; 5) total circulation. (A reduction in total cardiac output to 12% is critical for the brain). (Table II)

TABLE II

Factors Influencing Determination of Death

1. Nature of Human Being
2. State of Unconsciousness
3. Prognosis-Decision
4. Means to Manage
5. Patient's Rights—Wishes of Patient
6. Physician's Responsibility
7. Economics
8. Emotional—Sentimentality and Pity
9. Society's Demands
10. Legal Implications
11. Morality
12. Nature of Death

The Dying Process

Three phases of deterioration leading to absolute clinical death can be recognized. These are modified from Kramer[6] and are designated as: 1) disordered function (disequilibration); 2) disintegration; and 3) deanimation.

In the first phase, disordered function, each organ system or part of the body deteriorates functionally, insofar as it is integrated with, and coordinated with, other organ systems of the body. This may be considered as a period of early clinical death. It is reversible if resuscitation measures are immediately instituted and complete recovery is not only possible, but probable, if direct injury with destruction of the tissues has not occurred at the brain or heart levels.

The second phase of intrinsic disintegration represents deterioration of an organ itself with regard to its capacity to respond. In a sense this is the loss of extrinsic regulation and leaves only an automatic vegeative or intrinsic cellular autoregulation. This is a critical period but revival, and even complete reanimation, is still possible. This is a period of intermediate clinical death.

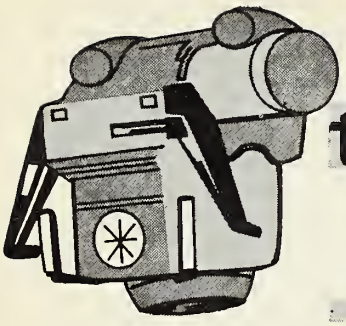
The third phase is a period of progressive deanimation when structural damage and tissue disintegration begin. This phase has been referred to as annihilation as evidenced by the isoelectric electroencephalogram. During this time there is a progressive loss of organ autoregulation accompanied by cellular changes and damage and subsequent necrosis.

Some injuries or causative factors, however, may be directly and immediately destructive of cellular integrity. This is not a reversible situation. Complete reanimation is not possible. A semblance of life may be attained artificially from 24 to 72 hours. But this is vegetative existence. Human life, or, indeed, an organized life, is not possible. However, some organs may be kept alive at the cellular or biological level, if the resuscitation technics are applied effectively before complete loss of autoregulation occurs. Individual organs may be alive at this simple tissue level, but the sum of all these does not result in an integrated whole.

Cessation of life functions or clinical death at the organ-system level leads to cellular death or what is more appropriately called biological death. Some cells may be kept alive in a primitive sense by perfusion technics. This is done *in vitro* in the laboratory but can occur clinically by artificial means and represents a heart-lung preparation.

As a consequence of late institution of resuscitation procedures, many organs and tissues may show cellular dissolution or complete structural destruction when examined post mortem. With respect to the brain, a tissue-culture preparation could exist if the artificial methods of resuscitation are continued after clinical death or after hope of restoration to spontaneous function and total reanimation is possible. Such a period of time during which cellular autolysis is progressing is often called the incubation-brain and produces the phenomenon of respirator brain syndrome.[7]

(To be continued next month.)



the view box

Leon Love, M.D./Chairman/Department of Radiology
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A 60 year old female entered the hospital with a history of severe acute abdominal pain of about 12 hours in duration. Physical examination revealed distension of the abdomen, temperature of 101°, and tenderness over the right side of the abdomen. (Figure 1 and 2)



Figure 1

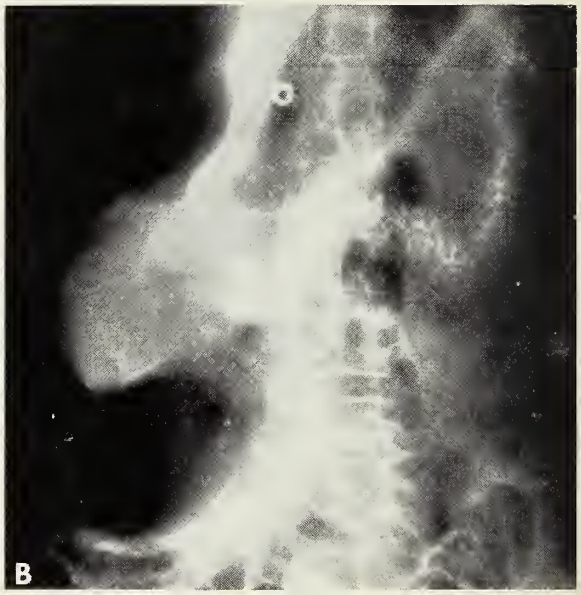


Figure 2

What's your diagnosis?

1. Diverticulitis
2. Obstructing carcinoma of the transverse colon
3. Volvulus of the transverse colon
4. Gallstone ileus

(Answers on page 556)

The Necessity for New Colleague Relationships Between Professionals

By Rosanne Krcek Frank, R.N., M.S.Ed. and
Irving Frank, M.D., Ed.D./Sycamore

The authors attempt to identify areas of conflict between medical and nursing professionals which have arisen because of the surge of inevitable changes in health care. They discuss new educational patterns which have given rise to the nurse specialist who, as part of the health team, is in a position to assume a responsibility in the delivery of primary health care. They urge a cooperative and collaborative effort to develop new colleague relationships which would result in mutual trust and respect for each other's expertise.

The spectre of federal regulatory processes mandating role change, with the threat of loss of professional autonomy, becomes a compelling incentive for the resolution of conflicting areas in professional relationships. Change is inevitable in our health care system. There is a need for flexibility and free movement of roles within the system. Rigidity in relationships between personnel of both professions proves destructive to otherwise good programs resulting in poor and inefficient health care delivery.

There is observable within the medical community today a peculiar type of psycho-social stress. The primary symptom is an exacerbation of what has been referred to as the "doctor-nurse game," in all its most destructive ramifications. We object very strenously to this euphemistic approach toward serious evidence of dis-equilibrium in a very important area of human relationships. Changes in significant roles within the health care team have created tensions. The resultant anxiety and hostile encounters have often had a deleterious effect on the delivery of health care to the ultimate consumer—the patient.

Views of the Problem

There has been a spate of articles on the subject, but interestingly enough most of them only in the nursing literature. We propose to discuss the problem as educators and members of the two professions, medicine and nursing, which have by tradition evolved as the leaders of the health care team. It is appalling to observe the anarchy and confusion which is apparent on the total health scene. As psychiatrically oriented professionals we must turn our attention to the inter-professional conflicts permeating the entire structure.

The mischief is compounded because of the multiplicity of factors feeding into the over-all situation. For purposes of this discussion we have identified four important variables which are pertinent facets of the problem. These are: 1) the upsurge of consumer demands; 2) the women's lib. movement which has created a demand for greater participation at all levels of the decision making and implementing process by women; 3) changing educational patterns in medicine and nursing, and 4) threats to traditional hierarchical positions, especially the entrenched position of the M.D. These can be designated as being the most productive of conflict. Anarchy may seem to be a strong term, but not when considered within the context of the proliferation of suggestions for new manpower categories to help alleviate what is being categorized as a crisis in the delivery of health services to the American public.

A review of the literature shows that these proposals run the gamut from that of a new type of health worker, most closely resembling the 'feldsher' of the Soviet Union, or even the 'Barefoot Doctor' of the People's Republic of China, to a "super-nurse" who is accused by many of wanting



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Dr. and Mrs. Frank hove warked together on numeraus articles about psychosamatic medicine and the changing rales of members of the heolth profession.

to be a junior physician. When physicians of the state of Illinois were asked in an official questionnaire by the ISMS how they felt about the introduction of the feldsher concept to the American scene we felt that indeed the time had come to take a good hard look at the total picture. There would seem to be real cause to ponder on the credibility gap. In the name of "better medicine" for the masses, we contemplate the creation of a health worker developed to give the most elementary type of care to the peasantry of underdeveloped rural regions of Czarist Russia!

Trends in Training Health Care Personnel

Even a cursory examination of the literature of the past decade serves to make one aware of the fact that there is a polarization toward two diametrically opposed trends in the preparation of members of the health care team. Medicine and nursing are each following a course of action which is resulting in an ever widening and disastrous schism between them. The medical profession, caught up in a real concern about the shortage of health care personnel, is involved, in a frenetic fashion, in various plans to produce the most bodies in the shortest length of time, all of whom would serve under the direct supervision of the physician. This trend has been obvious since 1965 when Silver and Ford came on the scene with their new "pediatric assistant,"[1] and in 1972 when the American Medical Association announced a plan to create 100,000 physician's assistants!

The authors, who have been involved in curricula development, are concerned because of the obvious paradox here. One would assume that the greater the technology the greater the need for educational preparation, but the physician seems to be under the illusion that he can place, as his first assistant, a paramedical individual with less and less educational preparation. So—a professional whose own educational status is constantly being upgraded in order to cope with the "knowledge explosion" is advocating solutions which are incompatible with an increasingly complex society. The contradictions become even more apparent when one considers that there is a serious movement to cut down the initial medical curriculum in order to hasten the fledgling doctor out into that 'real world' which needs him so sorely.

Interestingly enough, in the search for viable solutions to increasing demands being made upon him, the physician is busy overlooking the one member of the health care team who is rapidly being prepared to assume a role as his colleague —the nurse. She (he), is involved in upgrading her education in order to keep pace with technological advances, and incorporating a broad background in the behavioral sciences in order to cope with psycho-social problems in a comprehensive approach to health care.

At about the same time that medicine began fomenting all sorts of plans for rapid production of finger-in-the-dike personnel, the American Nurses Association made a decisive move to change the course of American nursing. It came out with its famous, or sometimes thought infamous, Position Paper on the Education of Nurses wherein they advocated the abolishment of the diploma programs, and mandated the academic route to becoming an autonomous and respected profession.

The goal was to create a professional who could take her place as a colleague with other members of the health care team, and to accomplish this her education had to be re-routed through higher educational institutions. She thus would receive a broader background in the liberal arts, the sciences, and the behavioral sciences and humanities. Of necessity, programs for the Master's degree and Doctoral preparation had to be instituted.

Since titles today seem to be assuming some mystical importance, as her education and role would change so would her title. The result is a proliferation of various categories of nurse-workers on the scene: nurse practitioners, family nurse practitioners, psychiatric nurse associates, nurse-scientists, medical nurse practitioners—it seems to go on ad infinitum compounding the confusion. The important thing, at this moment in time, is that there is a profound change. It would seem to be a progressive change, if one adheres to the belief that stagnation and inability to adapt to new situations leads to professional extinction.

Roles of Health Care Personnel

We talk about *role definition* and *role change*. The term *role* implies a set of behaviors. Crucial to an understanding of role change is the concept of role expectations: by self and by others. The medical profession, by and large, is quite unaware of the potential for improvement on the health care scene if this nurse is properly utilized, perhaps because nursing chose to ignore the potential benefits that might have accrued if they had planned for a multi-disciplinary input in the educational process. The whole situation is in a

state of flux; there is confusion as to what responsibilities need to be transferred, and more important, how to transfer them painlessly within a viable system. Familiarity with other members of the health care team during the educational process would undoubtedly make this easier.

Change is inevitable, therefore the need for cooperation is mandatory between members of the health care team. There cannot be a fixed position for any of the team members. Roles must be flexible. We have written previously of situations in which individual members occupying primary or secondary roles had switched their relative positions as new developments occurred.[2] There were substantiated benefits to patients being treated for psychosomatic disorders when nurse and physician were able to be flexible in their roles.

Within the frame of operation in Kurt Lewin's field theory, free movement is essential. Interchangeability of roles must be acceptable at all levels of operation. Flexibility is essential if there is to be harmony and balance within the system. Recent reports from the Denver meeting of the American Psychiatric Association indicate that rigidity in relationships between personnel has been one of the factors in destroying otherwise good programs in the field of community health, for example.[3] Dr. John Spiegel, President of the A.P.A. said,

> *"We are much in a state of flux, at a threshold. Everyone is anxious—no one likes change —especially the long-term, one-to-one practioners. Now there is much experimentation with roles in the treatment setting. No one minds, it is innovative. There may be more concern later, as roles begin to calcify, but out of the turmoil . . . will come the right system."*

Achieving Role Definition

The nurse, moving from her traditional role to a new one finds herself confronted with an environment in which she is not comfortable; facing ambiguity, the situation is unclear for her. She has to clarify her position in her interaction with the authoritarian forces she encounters. She may perceive these forces as hostile to her struggle to establish a new image. Her new academic achievements seem to result only in role pauperization, stirring up angry, hostile feelings, forcing her into an *activist* position. She is unrewarded either with role satisfaction or economic gains.

The question we must ask ourselves is: do we accept this well educated nurse as a colleague, and if so what is to be our role in helping a colleague get recognition for academic preparation with equitable compensation for new and continually expanding responsibilities. Or is she to achieve her proper position in the medical hierarchy through means other members of the labor force have used? This route often results in the interruption of health care delivery, as happened on the west coast when there was a massive strike of nursing professionals.

It is the activist female role which has been criticized as too aggressive, and the male dominant medical profession has found this threatening in its traditionally oriented approach to inter-personal relationships with members of the health care team. Many physicians find these well educated female activists too challenging because of their inability to cope with intimate day to day working relationships in an egalitarian fashion.

The tension is aggravated because the traditional M.D. role is threatened by many forces—consumerism, federal regulation and threats of complete derrogation of the professionalism which the medical profession has struggled to achieve over the past one hundred years. One need only take a glimpse at what is happening to our colleagues in Sweden who have suffered the fate of being relegated to the position of paid laborers, to see the subsequent poor job satisfaction caused by these political changes. For this reason it should be apparent that team efforts are needed to elevate the public image of all health care workers. Stereotypical approaches to each other must be discarded. Accountability and responsibility for role definitions, and ultimate actions, must be clearly identified by both nurse and physician. Both professions are involved in the process of developing self-regulatory processes, and colleague relationships can be built upon mutual trust and respect for the other's expertise.

New Nursing Responsibilities

It is currently fashionable to level all diatribes against the medical profession regardless of culpability. In fairness, however, it must be pointed out that nursing, and nursing educators are doing very little to help alleviate the gaps in our health care system. By and large present educational programs in nursing are based on an incorrect premise, namely, that nursing is an independent profession by virtue of an educational format which does not allow for any involvement of other professionals. A vestige of the days when medical teachers were totally responsible for the education of the nurse, we have now matured so that the baby need not be thrown out with the bathwater. We must accept the fact that we are

(Continued on page 553)

Guest Editorial

What Is This About Substitution?

Who has the qualifications and experience necessary to select drugs in the best interest of patients—physicians or pharmacists? For most of us, the answer is obvious. But for some legislators the answer is pharmacists. How do they arrive at this conclusion?

Item: Pharmacists are more knowledgeable than physicians of the drug products available to patients.

Item: What knowledge physicians have often comes from detailmen who "brainwash" them into prescribing high priced brand-name drugs.

Item: Physicians are indifferent to the financial concerns of their patients and generally unaware of drug prices.

Item: Consumers would reap large savings if cheaper "generic" drugs were substituted in place of brand name drugs.

Result: A legislative proposal that would permit pharmacists to substitute cheaper drugs for the ones you originally prescribed. This would be done without your prior knowledge or consent unless "no substitution" is specified in writing on the prescription form.

Unfortunately for patients, such proposals completely ignore scientific and economic evidence as well as your practical knowledge of drug usage. In a special report to Congress in July, 1974, the Office of Technology Assessment concluded, "Current standards and regulatory practices do not assure bioequivalence for drug products . . . the problem of bioinequivalency in chemically equivalent products is a real one. . ."

The report went on to make specific recommendations that would assure uniform drug product effectiveness in the future. They included new standards for good manufacturing practices, additional research techniques for bioequivalence and a new single standard setting organization. But until the government implements such recommendations, drug equivalency cannot be guaranteed or assumed. Similar efforts by this state would risk conflict with future U.S. standards and cost the state's taxpayers hundreds of thousands, perhaps millions of unnecessary dollars.

Experience shows that consumer savings on prescription drugs are nonexistent in the three states and five Canadian provinces where substitution is legal. In fact, a study of Saskatchewan conducted by Professor William Tindall of Creighton University revealed that instead of prices going down for those prescriptions in which the pharmacist gave a different company's product, they went up 19 percent. The study cited pharmacists' increased liability insurance as a possible reason. In our state, a substitution agreement between physicians and pharmacists in Kane County was cancelled by the county medical society after 15 months when a survey showed (among other failures) no consumer savings. An adverse drug reaction initiated the society's investigation after the "Brand Interchange" agreement was begun.[1]

While disregarding scientific and economic factors, substitution proponents would cast aside the only current proven safeguard to the dangers of inequivalency. And that is to depend on your judgment which is based on practical experience with particular drug products and clinical knowledge of individual patients. With the repeal of present state antisubstitution laws, your decision to select a specific drug product for patients would be dramatically converted into a virtually meaningless exercise.

Imagine how this could affect your day to day practice. For example, suppose the medication that the pharmacist substituted for your prescribed brand doesn't work? How are you to guage what's wrong? You know how the prescribed brand works, but since the pharmacist substituted without your knowledge, you have no way of judging the substitute. Did the substituted drug deliver as much of its potency to the patient as the brand that you prescribed? There's no telling. Meanwhile your patient incurs additional expense due to prolongation of illness.

Fortunately, substitution legislation can be defeated, and has been in other states. But the combined efforts of individual physicians on the local level play a key part. Here's a check list of how you can help fight substitution legislation.

- Contact your state medical society's legislative office and find out if a substitution bill has been introduced to the legislature, and if so, get the number assigned to the bill. Then, write your state legislator (referring to the bill by number) and give your opinion on substitution. It's important that you write rather than call, because although your letter may not receive immediate attention, chances are it will be reviewed when it comes

time to vote, and your opinion could have considerable influence.

- Contact your pharmacists, If they have views on substitution similar to yours, make sure they understand that you want *all* of your prescriptions filled exactly as written—no substitutions without your prior consent.
- When you read the local newspaper, if you notice an article on substitution or generic prescribing that doesn't give all the facts, don't be afraid to write a letter to the editor on the other side of the story.
- Air your views about substitution at your local society meetings. Offer to serve as a society spokesman on the issue. Encourage society officers and other members to become active.
- When you hear of appropriate hearings on prescription drugs, offer your expertise either as a witness or as a source of information for the hearing's investigative staff. Let the state society know that you are willing to serve as a source. They may have some special legislative or public relations programs where your expertise and views on substitution are needed.
- When you have the opportunity to address groups in your community, make the subject substitution. It's a timely, interesting and informative subject that just about any group can relate to. Typical groups might be medical school classes, hospital staffs, local medical societies and senior citizen's groups.
- Most important, talk to your fellow physicians—whether it's just a casual phone call or a society event. Encourage them to voice their opinions on substitution.

Without combined individual efforts, substitution could sneak by without the legislature or public knowing the consequences of such legislation. It's up to us to inform them because the more opinions voiced, the louder the voice, and the louder the voice, the more likely the defeat of substitution. ◄

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Francis A. Davis, M.D.

This editorial is based on an article published in Private Practice magazine.

New Colleague Relationships

(Continued from page 551)

inter-dependent, and plan for new patterns in allocating work responsibilities.

As outlined by the American Nurses Association Standards of Psychiatric-Mental Health Nursing practice, it is incumbent upon the nurse to employ an inter-disciplinary team approach which requires coordination and inter-dependent planning. There is great emphasis in her educational preparation on the social, cultural, economic and political components of health care problems. She wishes to assume her place as provider of direct patient care, and comes prepared to help cope with the psycho-sociologic aspects of the patient's environment, working with patients on the here and now living problems they confront, accepting and using the surrogate parent role, teaching with specific reference to emotional health as evidenced by various behavioral patterns. She is being taught to place emphasis on the cooperative, collaborative relationships essential to providing high quality care.

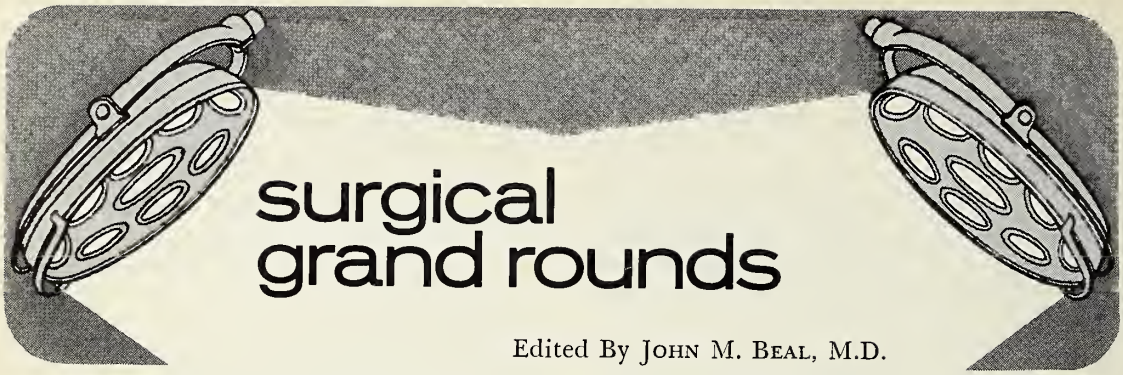
New federal programs are rapidly moving the R.N. into an active role in the provision of primary health care. This shift from the passive to a more active role has resulted in unexpected responses from many quarters. It threatens old nursing philosophies, it frequently elicits an ambivalent response by the medical profession, but in most instances patients have been most accepting of the nurse's contribution to their health care. With the nurse's growing ability to move into the psychosocial area of health care her role may sometimes overlap with medicine, but the doctor-nurse team should then be able to identify and meet a wider spectrum of patient needs.

Change is inevitable. We must address ourselves to the problem even though these changes may be painful. Perhaps—as the Walrus said, "The time has come . . ." for some basic changes in our individual and professional relationships, at least in our work life. ◄

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3. American Psychiatric Association, 26th Institute on Hospital and Community Psychiatry, Sept. 30-Oct. 3, 1974, Denver, Colorado. Address by Dr. John Spiegel, Pres.

Other bibliography available, on request, from: Irving Frank, M.D., Ed.D., 135 S. Sacramento, Sycamore, Ill. 60178.



Edited By JOHN M. BEAL, M.D.

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium at Passavant Memorial Hospital. Patient presentations from Passavant, Chicago Wesley Memorial and the Veterans Administration Research Hospitals form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 5, 1972.

Obstructing Duodenal Ulcer

Dr. Arthur Curtis: A 50 year old white woman was found to have a duodenal ulcer in 1958. In 1962, the ulcer was thought to be gastric in location. On each occasion, she had clinical and X-ray improvement after medical treatment in a hospital, and in the intervening ten years, she was well. She had occasional mild gastric distress for which she took Gelusil but was able to eat an unrestricted diet. Three months before the present admission, she developed a feeling of "gas" after eating with belching, bloating and borborygmus. She also had episodes of regurgitation of undigested food, especially after eating a large meal. At the time of admission, she had limited her intake to liquids. Her pain was described as gnawing and cramping in character in the mid abdomen. Initially relieved by Gelusil, but it became more persistant and was relieved only by vomiting. She lost 10 pounds in these three months. She smoked one and a half packs of cigarettes daily. A sister was said to have a peptic ulcer.

Physical examination revealed a well developed, well nourished 50 year old white woman not in acute distress. Blood pressure was 120/70, pulse 76 and respirations 18. The only significant finding on her physical examination was slight tenderness in the mid epigastric region. Blood count, urinalysis and an SMA-12 were within normal limits. A bland gastric diet was given for five days. However, nasogastric intubation became necessary because of gastric retention. Electrocardiogram and chest X-ray were within normal limits. Radiologic studies included an upper gastrointestinal series, barium enema, cholecystogram and intravenous pyelogram. The gallbladder filled without stones. Esophagogastroscopy revealed gastric outlet obstruction which the consultant thought was due to either scar or spasm. Twelve hour overnight gastric secretion was obtained. Free acid was 53.2 MEq. with a volume of 710 ml for the 12 hour period. On the 9th day of her medical therapy, 750 ml of normal saline was administered through the nasogastric tube during a 10 minute period. Thirty minutes later, 260 ml was aspirated. The next day the test was repeated and 390 ml remained in the stomach after 30 minutes. It was concluded that significant gastric outlet obstruction persisted despite intensive conservative therapy.

Dr. John Beal: The X-ray studies will be reviewed by Dr. Nudelman.

Dr. Earl J. Nudelman: The initial gastrointestinal series revealed a significant amount of retained barium in the stomach after four hours, at which time the barium column has not yet reached the cecum, but was in the small intestine. An ulcer crater was not demonstrated but the duodenal bulb was markedly deformed, (Fig. 1A and 1B).

Dr. L. Wikholm: This case is presented because it represents the application of vagotomy and pyloroplasty in a situation in which it has been said to be contraindicated. Vagotomy and pyloroplasty has gained wide popularity in the treatment of duodenal ulcer. This operation is used frequently in the surgical treatment of patients with duodenal ulcer who have pain, hemorrhage and occasionally perforation. However, many surgeons in this country have condemned it's use in patients with duodenal ulcer and ob-

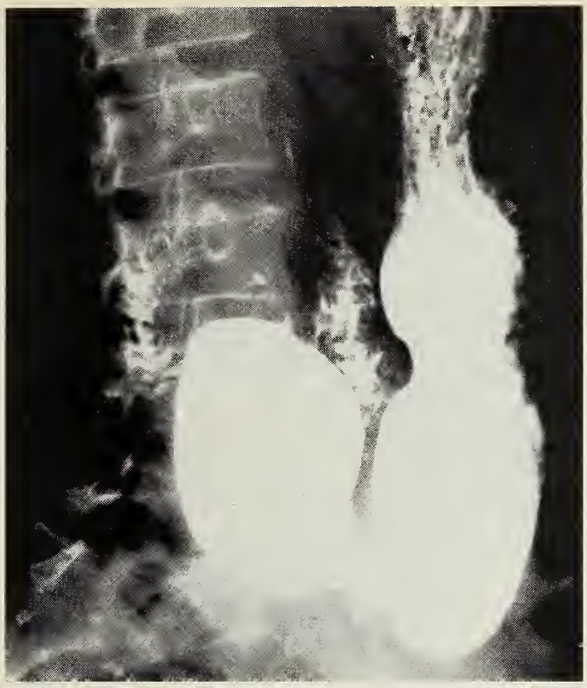


Figure 1A. Radiologic study of stomach demonstrated obstruction of gastric outlet with duodenal deformity.

struction. In his early works, Dragstedt demonstrated that gastric motility was greatly diminished following complete vagotomy. It has been concluded that this hypomotility, seen after vagotomy, is even more pronounced if the muscular wall of the stomach has been subjected to the chronic distension associated with longstanding pyloric stenosis. Weinberg in his study of a group of patients six months following vagotomy and pyloroplasty was able to show evidence of this gastric hypomotility in one-third of the patients. Thus he joined the group who recommended vagotomy and gastric resection, rather than pyloroplasty for obstructing duodenal ulcer.

In 1964, G. K. Smith, in discussion of a paper, stated that gastric hypomotility was not a major problem after vagotomy and drainage in his experience. This has been corroborated by surgeons in England. In March of 1971, Davis and Williams reported a series of 15 patients with a one to six year follow-up. All of these patients presented a history of chronic duodenal ulcer with gross duodenal stenosis demonstrated by X-ray studies. The patients ranged in age between the third to seventh decade of life. They usually had the triad of symptoms presented by our patient of pain, vomiting and weight loss. Our patient lost only 10 pounds, but this group had many patients who lost more than 20 pounds, and one patients who exhibited a 72 pound weight loss. Their duration of symptoms was usually about 10 years. Their radiologic criteria for duodenal obstruction were much as Dr. Nudelman has mentioned here. Four hour barium retention was present in almost every case, and in some cases a 24 hour retention occurred. Gastric dilation was noted and many had increased gastric output volume. These patients were treated by vagotomy and pyloroplasty, the majority with the Weinberg modification of the Heinecke-Mikulicz procedure. They utilized both truncal and selective vagotomy for post operative decompression. They sometimes used gastroscopy tubes, sometimes nasogastric tubes, and occasionally no tubes at all. Followup ranged from one to six years. Ulcer recurrence had not developed at the time they reported this particular series.

Several types of surgical procedures are available to the surgeon for the treatment of obstructing duodenal ulcer. One alternative is vagotomy and gastroenterostomy, which has been reported to have a relatively high incidence of stomal ulcer. Another procedure which is preferred by many surgeons is vagotomy and gastric resection. The main disadvantages of this procedure are the long-term post operative morbidity and slightly greater mortality. The main hazard in chronic duodenal ulcer after gastrectomy is leaking from the duodenal stump. The incidence of stomal ulcer is low. The afferent loop syndrome, dumping syndrome, and vitamin or nutritional deficiency occasionally follow these procedures.

Several types of pyloroplasty are available and are useful. The Jaboulay method is a side-to-side gastroduodenostomy which may be indicated



Figure 1B. Delayed film shows significant retention of barium four hours later.

when the pylorus is markedly stenotic or inflamed. The Finney pyloroplasty opens the duodenum widely and has been recommended for patients with a J-shaped stomach. The Weinberg pyloroplasty is accomplished by a single layer closure which allows minimal infolding at the anastomosis. The Hines modification was used in the patient presented today. This procedure begins with the customary incision through the gastric and duodenal walls, although the length can be decreased slightly when compared to the Weinberg method. After the anterior wall is opened, the posterior portion of pyloric muscle is identified, and two Babock clamps are placed on the muscle. Then the posterior wall is cut longitudinally between these clamps for a short distance, thus dividing the posterior portion of the pyloric muscle. Therefore, the pyloric muscle has been cut in two places, anteriorly and posteriorly. The anterior closure of the pyloroplasty is by the Weinberg method.

The patient who was presented today left the hospital after an uneventful post operative recovery. An upper gastrointestinal series was performed six weeks after the operation.

Dr. Earl J. Nudelman: The one hour film shows normal gastric emptying and no other evidence of gastric hypersecretion as was evident in the preoperative studies. The pyloric channel which was markedly narrowed, is now widely patent (Fig. 2). The duodenal bulb does not appear normal but demonstrates changes associated with operation. Irritability and spasm are absent.

Dr. James Hines: Six weeks after the operation, the patient is eating a general diet without distress. This procedure has been employed in 10 patients with obstructing duodenal ulcer and recurrence of symptoms have been absent for a period from 6 months to 2 years. Incidentally, it is important to inspect the duodenum carefully because the obstructed area may be in the second portion. If the point of obstruction is farther down the duodenal, a proximal pyloroplasty will be ineffective no matter what type is used. In performing vagotomy and pyloroplasty, particularly in the treatment of obstructing duodenal ulcer, the pyloroplasty must be constructed so that gastric emptying is unimpaired by the pyloroplasty itself.

Dr. John Beal: How long did you use nasogastric drainage after the operation? Had you used a gastrostomy?

Dr. James Hines: Two days. We had not used a gastrostomy in this series. Prolonged drainage does not seem to be needed if the pyloroplasty is widely patent. ◄



Figure 2. Gastrointestinal roentgenograms were obtained six weeks after operation and demonstrate good gastric emptying.

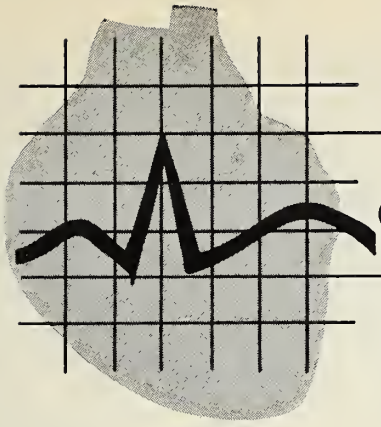
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Viewbox

(Continued from page 548)

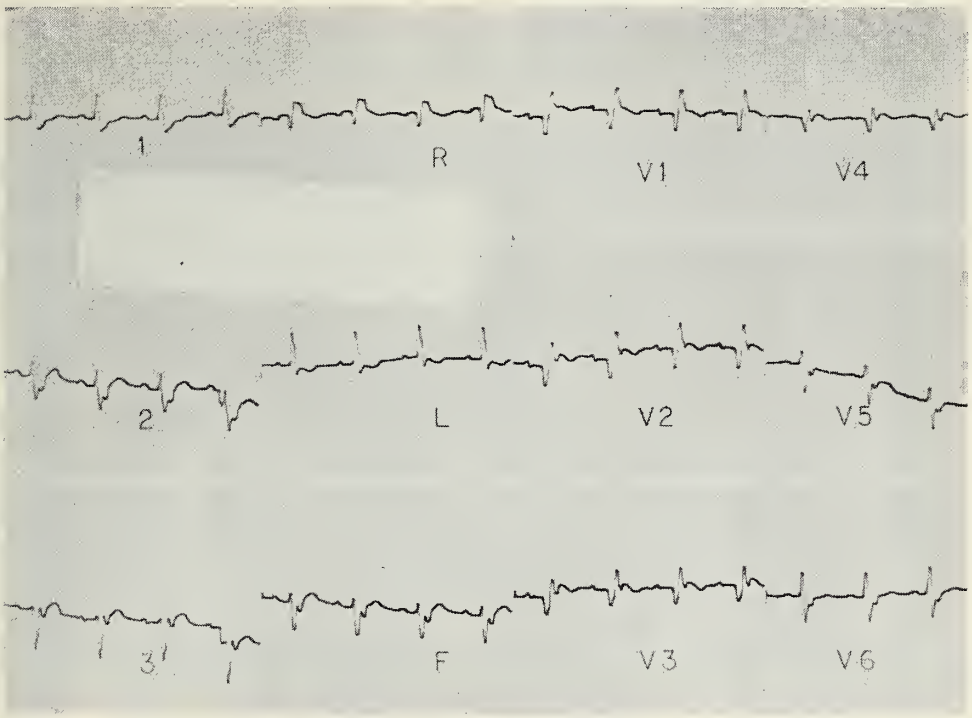
DIAGNOSIS: *Transverse colon volvulus*—This condition is extremely rare. A series from Finland recorded it in only 3 of 238 cases of volvulus. It is supposed to occur only when the transverse colon is very redundant and the flexures approach each other. The twist occurs at the level of the proximal transverse colon. The hepatic flexure is elevated under the right hemidiaphragm and there is associated small bowel distention. The upright film (Figure 1) reveals multiple loops of small bowel adjacent to a point of twist to the left of L-3. An earlier barium enema showed a redundant transverse colon. The loop of bowel under the right hemidiaphragm represents distended hepatic flexure. Colon examination (Figure 2) demonstrates typical "bird of prey" sign in the midtransverse colon. Operation revealed necrosis of the cecum, ascending colon, and a portion of the transverse colon proximal to the site of volvulus.



ekg of the month

John R. Tobin, Jr., M.S., M.D., Rimgaudas Nemickas, M.D., Patrick J. Scanlon, M.D., John F. Moran, M.S., M.D., Sarah Johnson, M.D., and Rolf M. Gunnar, M.S., M.D./
Section of Cardiology, Department of Medicine,
Loyola University Stritch School of Medicine

A 72 year old widow was admitted from the emergency room complaining of recent onset of burning retrosternal discomfort radiating into both arms. On examination, she was slightly breathless and diaphoretic. Blood pressure was 180/110 mmHg. A loud S_4 could be heard at the apex. Electrocardiogram taken in the emergency room was within normal limits. Two hours later the following tracing was obtained.



Questions:

1. The electrocardiogram demonstrates:

A. Right ventricular hypertrophy (RVH).
B. Right bundle branch block (RBBB).
C. Pre-excitation syndrome (Wolff-Parkinson-White).
D. Acute anteroseptal myocardial infarction.
E. Left bundle branch block (LBBB).

2. The following clinical events could be expected:

A. High grade A-V block.
B. Prolonged asystole.
C. Insertion of a transvenous pacemaker.
D. Return of blood pressure to normal.
E. Death secondary to pump failure 3rd week.

(Answers on page 585)

Impressive Springfield



Dr. J. M. Ingalls, ISMS President, keynotes the opening workshop/briefing. Seated at the head table (from left) are Dr. J. E. Reisch, ISMS Secretary-Treasurer; Dr. Elliott Partridge, Chairman, ISMS Public Affairs Committee; Bob Kjaellander, ISMS staff; Dr. Fredric Lake, Immediate Past President of ISMS and Chairman of the Task Force on Professional Liability; and Dr. Joseph Bordenave, Chairman of the ISMS Board of Trustees.

On Wednesday, May 14, over 300 physicians, joined by some 100 of their wives as well as Auxiliary members, Medical Assistants, hospital administrators, and osteopathic physicians, met in Springfield for the annual Legislative Day sponsored by the ISMS Public Affairs Committee. The overflow throng jammed into a morning session to be briefed on current legislation important to medicine and the delivery and availability of health care.

Keynote for the meeting was Dr. J. M. Ingalls, ISMS President, who encouraged all in attendance to make a sincere effort to have their viewpoints known by the legislators and to get their colleagues back home to do likewise. Following a briefing on several legislative matters by Governmental Affairs Director Don Udstuen, Dr. Fredric Lake, Chairman of the ISMS Task Force on Professional Liability, recapped the activities leading up to current bills aimed at alleviating an impending crisis.

The program chairman, Dr. Elliott Partridge, then identified the day's activities and with the help of Bob Kjaellander, Assistant Director of Governmental Affairs, instruct-



Part of the scene during registration of nearly 400 attendees.





Rapt attention of attendees during morning workshop/briefing session led by ISMS leadership.



The entourage arrived at the Capitol via chartered bus. Pictured are Mrs. Willard C. Scrivner followed by Dr. Eli Borkon.



Drs. James Haughton (2nd from right) and Philip Thomsen (far right) discussing matters with legislators on the Capitol approach.



House Majority Leader, Representative Gerald Shea briefs the group on the malpractice bills.

Legislative Conference



ed the attendees in how to call members from the floor, where to find offices and so on.

Busses were provided to transport the "lobbyists" to the Capitol, where many physicians took their legislators to lunch. Unfortunately, a bomb threat resulted in the closing of the state building complex for nearly two hours. Undaunted by this interruption and delay, the physicians literally charged ahead when the all clear was given.

Imagine the scene, with nearly 400 people "pounding at the door" calling for their legislators. Police were called to keep order and to keep the aisles clear. Many legislators commented that this was most impressive and several indicated that this was the first time a physician had ever appeared in Springfield to lobby him personally. A two hour briefing session with the leadership of both chambers and key legislators provided in depth exchanges and an appreciation for the concerns of the legislators.

As a result of this, medicine's views were made known most emphatically! And the legislature responded. In the Senate, the ISMS-IHA endorsed bill on malpractice (SB 1024) was passed by a vote of 51-4. The House, due to calendar difficulties, did not pass any bill on this. But all ISMS amendments had been accepted and the Bill (HB 2769) was at passage stage when the calendar set by rules ran out.



Representative Bruce Richmond (3rd from left) listens to presentations by physicians from his district.



DuPage County physicians discuss situation with their Senator, James Philip (2nd from left).



Police called to maintain order in the Capitol.



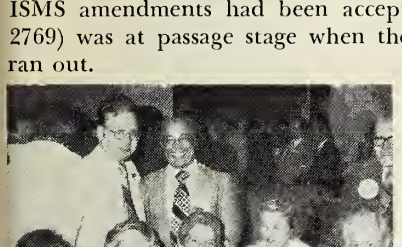
Senator Don Moore (back to camera) is buttonholed by attendees outside the gallery.

Following the frenetic activity on the bill, a reception was held for members of the legislature. This opportunity was also the scene of some intensive jawboning, as well as friendship and comaraderie. As the evening wore on, several dinner engagements between the physicians and the legislators further strengthened the ties which had been established.

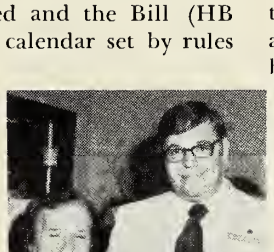
It was an exciting day. It was a challenging day. It was a tiring day. But most of all, it was a successful day!

This was the largest group ever to attend this annual event. It demonstrated to the Legislators that medicine is concerned and is a visible, dynamic group.

Kudos to the Public Affairs Committee, the Governmental Affairs Council, and the Officers and Trustees for a most heartening activity. Hopefully, all members will plan now to become more greatly involved in public affairs activity and will begin planning to be in attendance at an even bigger and better Legislative Day next year.



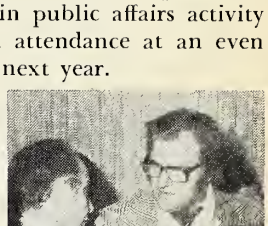
Dinner table group from Belleville with Senator Kenneth Hall (center back) and Representative Celeste Stiehl (center front).



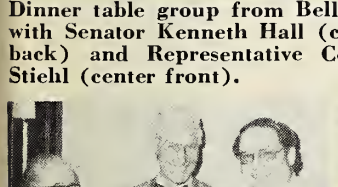
Senator Sam Vadalabene poses with Dr. George Wilkins during a busy day.



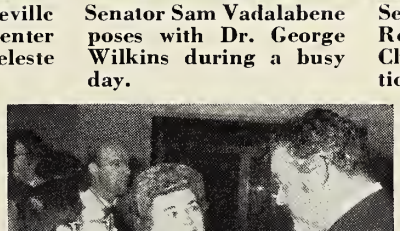
Senator David J. Regner and Representative Eugenia S. Chapman relax at the reception.



Dr. George Andrews (left) of the Osteopathic Physicians Association talks to Representative Edward Bluthardt (right).



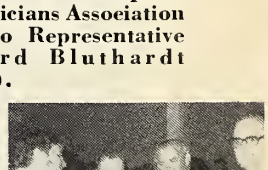
Drs. Philip Thomsen and Howard Schneider talk with Representative L. Michael Getty from Dolton.



Representative Virginia Macdonald (center) listens to physicians.

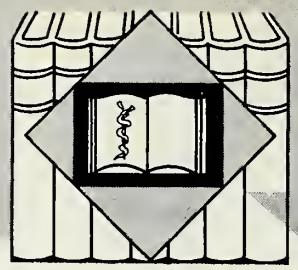


Group of physicians from Cook County talking with Representative Richard Newhouse (2nd from left).



Representative Paul Stone (2nd from left) enjoys conviviality of reception with physicians.

the doctor's library



IMMUNOLOGY, IMMUNOPATHOLOGY, AND IMMUNITY. Stewart Sell. Harper and Row, Publishers, Inc., 1972. 277 pp. 45 illus. Price $12.95.

Those physicians—and they are many—who still view immunology as a little appendage of bacteriology or microbiology are not only missing its basic relationship to the life processes but also overlooking both important evidence of disease and useful therapeutic opportunities among the patients who consult them. Dr. Sell explains: "Immune reactions of both humoral and cellular types play important roles in the defense of the host against infections agents. . . . However, we increasingly recognize instances, in which the immune reaction of the host produces tissue damage (disease). . . . In a strict sense, some instances of altered reactivity are not reactions of allergy or immunity: . . . Schwartzman reaction (alteration in the state of blood coagulation), adaptive enzyme sythesis (substrate selection of enzyme production), anaphylactoid reactions (pseudoallergic reactions from the liberation of pharmacologically active agents that may also be liberated by allergic reactions), reactions to drugs caused by nonallergic physiologic hyperactivity (idiosyncrasy), and other types of environmental adaptations (heat, cold, altitude, emotional) produced by nonimmune physiologic or psychologic mechanisms." He considers cytotoxic or cytolytic reactions, atopic or anaphylactic reaction, Arthus reaction, Schwartzman reaction, delayed (tuberculin-type) hypersensitivity, granulomatous reaction, collagen disease, drug allergy, immune deficiency diseases, immunology of cancer, and human solid tissue homografting.

For practicing physicians who completed their medical schooling only a few years ago as well as for students, interns, and residents, Dr. Sell has compressed a wealth of modern knowledge into very little space and presented it in an accurate, readable manner. Those who use it cannot expect it to be easy going but will find it well worth the effort required to learn this essential molecular biology.

William H. Wehrmacher, M.D.

GENERAL UROLOGY. 7th edition. Donald R. Smith. Lange Medical Publications, 436 pages. Price $8.50.

Since its introduction in 1957, GENERAL UROLOGY by Donald R. Smith has become a standard urologic text. The 7th edition has several improvements, most notably the chapters on embryology of the genitourinary system and on radioisotopic kidney studies. However, the value of the work lies in its broad general coverage of urology and its clear, simple text plus emphasis on overall principles rather than on obscure detail. The illustrations and photographs are clearly reproduced and easy to understand and the references at the end of each subject are excellent guides for further study.

This book is intended to be basic rather than exhaustive and its price makes it well accepted by medical students. It also serves very well the general practitioner or general surgeon who needs a working knowledge of urologic problems.

Earl F. Wendel, M.D.

REVIEW OF CURRENT PRACTICE IN ORTHOPAEDIC SURGERY, 1973. Editor: James P. Ahstrom, Jr., M.D. The C. V. Mosby Company. 1973.

This is the fifth volume in this series which attempts to discuss current and newer techniques in the diagnosis and treatment of orthopaedic disorders. The eleven chapters, each written by different contributors, are: Pollicization in Congenital Absence of the Thumb; Selected Observations on the Cervical Spine in the Child; Ligamentous Injuries of the Knee; Arthroscopy of the Knee; Management of Arthritis of the Knee Joint; Total Hip Replacement; Clinical Application of Polymethyl Methacrylate for Total Joint Replacement; Scoliosis in Cerebral Palsy; New Trends in the Operative Treatment of Scoliosis; Management of Low Back Pain; Orthopaedic Considerations in the Management of Muscular Dystrophy.

The authors are widely experienced in the treatment of the problems which they discuss and, therefore, their in-depth presentations of the topics are very useful. For the practitioner the chapters on arthroscopy of the knee by Dr. Robert W. Jackson, total hip replacement by Dr. Frank E. Stinchfield and associates, as well as the management of ligamentous injuries of the knee by Dr. Joseph D. Godfrey are of particular worth. Dr. Ian MacNab also has a valuable chapter on the management of low back pain, certainly a problem of almost epidemic proportions.

Overall, one can easily recommend this volume for those actively engaged in the clinical practice of orthopaedic surgery.

James W. Milgram, M.D.

Disorders of the Respiratory Tract in Children, Volume I, Second Edition. Edited by Edwin L. Kendig, Jr., 1972. W. B. Saunders Company.

This text contains contributions from 34 authors and is, as might be expected, of uneven quality. The descriptions of specific diseases, however, are frequently excellent. Examples of this are the chapter on pulmonary hemosiderosis by Douglas Heiner and the chapter on tuberculosis by Edwin Kendig.

The more generalized chapters are of much more variable value. The chapter on the functional basics of respiratory pathology by Victor Chernick and Mary Ellen Avery is a remarkably clear and concise presentation of a great deal of fundamental information as is the chapter concerning the intensive care of respiratory disorders by Reynaldo Pagtakhan and Victor Chernick. Some of the other rather general sections, however, are extremely weak. Possibly the low point is the remarkable statement (not use in the development of any more complex relationship) that "the surface of a circle, such as a horizontal cross section of the larynx, trachea or bronchi, is calculated by the formula πr^2."

The weak sections are, however, fairly obvious and certainly do not impair the value of this text as a reference work or, if read selectively, as an introduction to pulmonary disease. As such, it should be of great value to medical students, resident, pediatricians, and all physicians interested in chest disease.

Lewis E. Gibson, M.D.

Current Surgical Diagnosis and Treatment. Edited by J. Englebert Dunphy and Lawrence W. Way. Lange Medical Publications, Los Altos, California. 1973. 1108 Pages, Illustrated. $14.00.

This soft cover surgical textbook edited by J. Englebert Dunphy and Lawrence W. Way contains 52 well written and informative chapters. The chapters are well organized and the tables and illustrations add to the understanding of the material presented. The editors have accomplished their goal in presenting the essential and most recent material in as concise a manner as possible. Besides the basic type of information found in all surgical texts, there are separate chapters for Radiation Therapy and Nuclear Medicine. With the increasing use of irradiation both pre and post operatively, the basic principles and clinical application of this modality should be included in a surgical text. Similarly, the use of radioactive isotopes have broadened both the diagnostic and therapeutic approaches for a surgical patient.

In addition to including material not usually found in a surgical text, the editors have organized the chapters somewhat differently from the usual text. Pertinent up to date references are found after individual sections of a chapter instead of the usual listing of all references at the end of the chapter. This convenience should be most helpful to the busy student and resident. Also, many sections in each chapter begin with the subheading of "Essentials of Diagnosis." Here the most important symptoms, physical findings and laboratory results of the disease process are summarized in a few lines. A typical example is found in the section on Obstruction of the Small Bowel:

- Colicky abdominal pain
- Anorexia; nausea and vomiting
- Obstipation
- Abdominal distention
- Peristaltic rushes
- Dilated small bowel on x-ray

For the student, this information should be most helpful, especially if he is dealing with the disease process for the first time.

I would consider this text most suitable for the busy student and resident.

Gerald T. Ujiki, M.D.

A Model Free Clinic

By James S. Berry, M.D./Freeport

Several hundred free clinics have sprung up across the country in recent years in an effort to reach needy patients who have, for whatever reason—usually financial, been outside the traditional channels of medical care. A major drawback to most of these efforts has been the fact that they offer only intermittent care, often without the benefit of specialty consultation. This simply cannot be classified as the kind of comprehensive health care that physicians would wish for their regular patients. In addition these clinics have no provisions for comprehensive pharmaceutical services nor do they provide a mechanism for in hospital care. Another problem was their tendency in almost all cases to get involved in political controversy which did not add to the level of medical services being provided. A further very legitimate criticism is that in no sense are these clinics completely "free." After their inception they begin to seek tax funds and various other contributions to pay for their socalled free services. In many more than one such clinic around the country the "free, routine visits" have cost the tax payers as much as $40.00 apiece. In short, these operations are not the kind of approach to medical care of the indigent that knowledgable, conscientous physicians can endorse.

In Freeport, Illinois, and surrounding Stephenson County, (a population of 50,000) the medical community has developed a program which answers the objections noted above and meets medical needs in a manner which physicians can strongly approve. This project began in 1970-71, when a so-called free clinic was opened in Freeport without the participation of the medical community. Its inability to provide adequate medical service plus its burgeoning financial cost became progressively unacceptable and lead eventually to the medical community plan.

The thoughts of many people went into this plan. First, we were reasonably confident that the local problem of medical indigents was not overwhelming in number. Most of the people who felt themselves indigent were eligible for medicaid or other forms of already existing community financial assistance, but they did not know about the availability of these programs. The problems of the very poor and uneducated when confronting a bureaucracy are more formidable than many people realize. Secondly, we felt that we would not want to participate in a program unless we could find a means of salvaging the dignity of these people and at the same time bring them into the mainstream of medical care.



JAMES S. BERRY, M.D. is on orthopaedic surgeon in Freeport. He took his residency at St. Louis City Hospital. Presently he is vice president of the Northern Illinois Foundation for Medical Care.

The critical problem here at the outset was whether or not to employ any means test in determining eligibility for free medical care. We decided to forego means test and appeal directly to the goodwill of the community not to abuse our offer. In our plan patients would be accepted solely on their own recognizance. As there have been virtually no abuses of this we have never regreted this decision.

The final initial question was where could we hold this clinic without involving rentals and at the same time be able to tie in the various other social and professional services of the community. The Stephenson County Health Department is located in downtown Freeport, the major city of this area, located almost in the center of the county.

The Health Department had a large amount of available space including two examining rooms (plus examining tables) and a waiting area. These were used only for a monthly family planning clinic. We discussed our thoughts with Health Department officials who were and have remained very helpful. The department nurse agreed to be responsible for soliciting volunteer nursing and clerical help for the proposed clinic. We, of course, would provide volunteer physicians. The existing space and examining area and

files of the department would be employed so that no further or additional costs would be involved. The department also agreed to serve as a pipeline on behalf of poor patients to various other social agencies in the city and county so as to further enhance the services available to the poor. It seemed obvious at the time that anyone that was too poor to pay a routine medical fee also had a large number of other social needs which should also be approached. Clearly the county health department seemed like a good place to begin to solve this overall problem.

The Basic Plan

When the type and nature of the program was explained professional volunteers readily agreed to serve. 38 of the 45 local physicians, embracing all of the specialties, volunteered their services. Twelve dentists also volunteered to participate in the program, as well as the entire Stephenson County Optometric Society, several physical therapists, and the aforementioned nurses. We decided at the outset to have a walk in evening clinic every week. The clinic would be staffed by physicians on a rotating call list. The on call physician would treat then and there all easily treatable conditions. Anything more difficult or substantially outside of the purview of the attending physician would be referred to the appropriate participating specialists for ongoing care at the specialists office as a free private patient. The arrangement for free medical care was made between the county health nurse and the physician's nurse so that in the majority of cases the physician did not even know that he was treating a free patient. This introduction to a private physicians office was further facilitated by the printing at the County Health Department of a referral card which was presented at the time of appearance at the doctor's office. In-hospital care was also to be rendered free of charge to the individual.

As we soon learned about half of the patients were eligible for some form of public aid. When available this was arranged by the county health nurse with the applicable social agency. All participating physicians accept third party payment when available; however, the patient himself is never charged for any services received.

The thought also occurred at the outset that the clinic meeting once a week leaves a large service gap between clinic days. Obviously if people have problems such as hemorrhage they cannot wait until the next clinic day. Accordingly an ombudsman service was set up between the medical community and the county health nurse so that any calls directed to her that involved patients that could not wait until the subsequent clinic were referred to the medical community on that same day. This has only occurred about a dozen times since we have been in operation and in each case the patient involved has been scheduled into a private physicians office on the same day the complaint was received. This allows us to offer service throughout the week. We felt that this was important because our whole purpose was not just to approach medical indigents but to obliterate them.

Getting Started

We began our operation on a Monday evening in July of 1972 amid a considerable degree of skepticism on the part of many elements in the community. A rather discouraging total of 3 people appeared on the first night. We realized right away that however distasteful publicizing our efforts may be, we had to do it. In our first 20 months of weekly operation we saw about 700 individuals for a total of 800 contacts in the clinic itself. About 1500 additional free private office visits have stemmed from referrals made in the free clinic. Ten surgical procedures of various types have been done and approximately 65 babies have been delivered. Significantly, emergency obstetrical cases have virtually disappeared from our area.

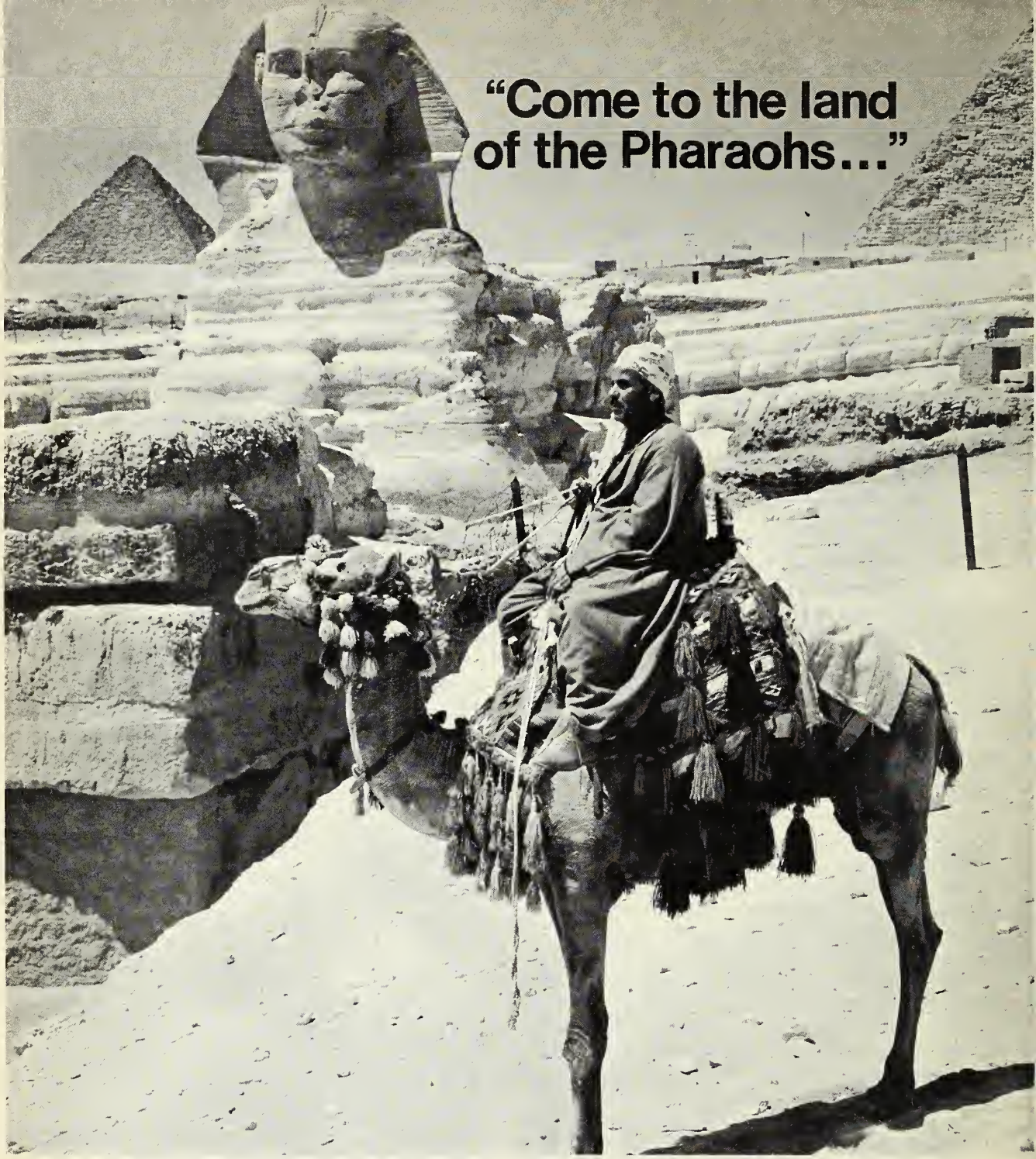
As we have gained more confidence in the efficacy of this operation we have not made any great pretense at limiting clients to Stephenson County residents. Some out of county people have appeared who we have treated without comment.

As noted previously, about half of the patients involved can, with help from our volunteers, get third party financial help. When this help is available the participating physicians do accept it. We feel this is only fair. The other half of these patients simply fall beyond any of the existing programs and are truely isolated from the mainstream of medical care. Like many medical communities, we were reluctant to believe this at the outset. However, our experience has demonstrated that this is a fact. These people exist in every community and they do need help. To these people we simply ask that they indicate to us their needs. We will take care of their medical problems no matter what these problems require in the way of care.

Additional Problems

As we progressed with this operation two other problems appeared. One was the cost of prescrip-

(Continued on page 581)



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Doctor's News

NEW TRUSTEES ELECTED FROM DISTRICTS 1A and 3 by the Board of Trustees. The trustee from District 1A will be P. John Seward, M.D., of Rockford. Elected as the additional trustee from District 3 was Joseph C. Sherrick, M.D., Chicago.

BOARD MAKES STATEMENT ON THE PROPRIETY OF PODIATRISTS PRESCRIBING anorectic and hypoglycemic drugs. When problems of the feet represent complications of a systemic disease the podiatrist is in keeping with the principles and practice of podiatry to proceed with local treatment. However the podiatrist would be exceeding his capacity and training if he prescribes any medications having a significant systemic effect.

ILLINOIS' FIRST SUPERINTENDENT OF THE DIVISION OF ALCOHOLISM is Mrs. Roalda J. Alderman, announced LeRoy P. Levitt, M.D., Director, Illinois Department of Mental Health and Developmental Disabilities.

Mrs. Alderman, previously Executive Administrator for the Illinois Department of Public Health Hospital and Clinics, Chicago, will be responsible for implementing PA 78-1270, "Illinois Alcoholism and Intoxification Treatment Act," in addition to planning and administering the Department's programs for the prevention and treatment of alcoholism.

DR. INGALLS "PRESIDENTIAL TOUR" will begin June 9 with a visit to the Saline-Pope-Hardin County Medical Society in Harrisburg. He will also attend the Jackson County Medical Society meeting in Carbondale on June 24. Other dates which have been confirmed for the tour are:

Date	County Society	Date	County Society
Sept. 11	Champaign	Nov. 4	Madison
Sept. 15	Adams	Nov. 11	Lake
Sept. 17	DuPage	Nov. 13	LaSalle
Oct. 2	North Side Branch, CMS	Nov. 20	Jefferson-Hamilton
		Nov. 25	Macon
Oct. 7	Morgan-Scott	Jan. 6	Winnebago
Oct. 8	Kane	Jan. 14	Will-Grundy
Oct. 14	Rock Island	Feb. 10	McLean
Oct. 21	Kankakee		

MORE BENEFITS FOR PHYSICIANS—Under new Federal Law, self-employed physicians will now be able to set aside, tax-free, 15% of earned income not to exceed $7,500 a year. This new arrangement is retroactive to July 1, 1974.

The bill also contains a minor restriction on corporation pension plans. Tax deferrals will not be allowed on savings that would exceed a pension that brings in more than 75% of highest earnings over a three year period, with a maximum potential retirement income of $75,000. A "grandfather" clause exempts current plans that exceed this standard.

GREATER ILLINOIS CHAPTER OF THE NATIONAL HEMOPHILIAC FOUNDATION will hold its third summer camp for boys with hemophilia this year. During the camping session a Pediatric Hematologist will be in residence, and facilities for infusion therapy will be on the premises. For further information contact the Chapter office at 327 South LaSalle Street, Room 1648, Chicago, Ill., 60604; or phone 427-1495.

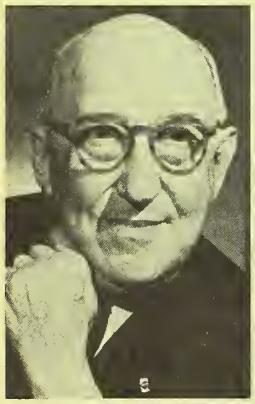
COMPETITION ANNOUNCED BY THE INSTITUTE OF MEDICINE OF CHICAGO for the 1975 Joseph A. Capps Prize and the Dr. and Mrs. Elven J. Berkheiser Prize. The Capps Prize is given for the most meritorious research in medicine or in the specialties of medicine. The Berkheiser Prize is for the best thesis for original research work in the field of orthopaedic surgery. The greater part of the work must have been completed in a Metropolitan Chicago institution. Competition for both prizes is open to physicians who received their M.D. degree six years or less prior to July 1, 1975.

U.S. ARMY GEN. ANDREW J. GOODPASTER spoke at the annual St. Clair County Medical Society Public Affairs dinner in Belleville on May 1. Goodpaster spoke about U.S. national security in the 1970's with a review of the past two decades. President Gerald Ford sent a telegram to Goodpaster commending him for his accomplishments in "a lifetime of selfless service to America" which shall serve as an inspiration to civic-minded groups throughout the country.

PHYSICIANS IN THE NEWS—Leon Unger, M.D., Chicago, has received the honor of the Fellow Distinguished Award from the American College of Allergists.

Recently named to the Board of Directors of the National Society for the Prevention of Blindness is **David Shoch, M.D.,** Professor and Chairman, Department of Ophthalmology, Northwestern University, Chicago.

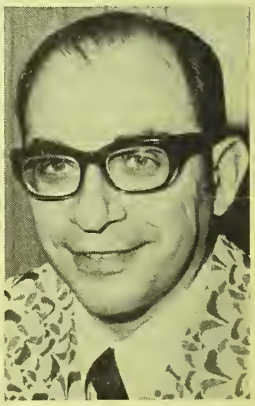
Maurice L. Bogdonoff, M.D., senior attending radiologist and director of thoracic radiology in the department of radiology and professor of diagnostic radiology and internal medicine at Rust Presbyterian-St. Luke's Medical Center, was recently elected president of the Center's medical staff.



Dr. Fishbein

Morris Fishbein, M.D., famed physician, editor and medical statesman was honored by Jackson Park Hospital and the Medical Division, State of Israel Bonds at a testimonial dinner May 7, 1975. Dr. Fishbein is being honored for his countless contributions to medicine, education and the economic development of the State of Israel through his participation in the Israel Bond program.

Giles B. Mizock, M.D., Chicago obstetrician and gynecologist, was honored by West Ridge Sunset Lodge B'nai B'rith at its annual State of Israel Bond testimonial dinner, May 3, 1975, for his leadership in the B'nai B'rith and for his efforts to assure Israel's economic survival through the Israel Bond drive.



Dr. Mizock

report

Illinois Society
American Association of Medical Assistants

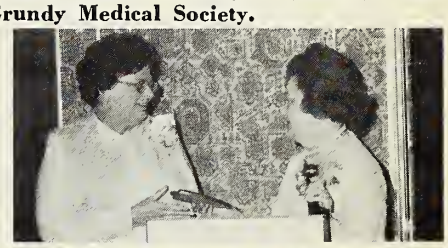
Highlights of 19th Annual Convention

The 19th Annual Convention of the American Association of Medical Assistants, Illinois Society was held at the Holiday Inn South in Joliet. Entitled "Unlimited Horizons," the convention featured clinical lectures as well as society business. Lectures were presented on "Office Productivity," "Rape and Evidence," and "Clinical Hypnosis." There was also a panel discussion, lead by Leonard A. Klafta, M.D., FACS; Judge Michael Orenic, and Rev. John Huff, about "Euthanasia." The convention was very successful.



Right: Richard Riley, President, Will Grundy Chapter; Norma Domanic and Cissy Moran, Convention Co-Chairmen, J. M. Ingalls, M.D., President ISMS and (center back) Albert W. Ray, Jr., M.D., President, Will Grundy Medical Society.





Left: Vivian Johnson presenting Mrs. Carl Clark with Appreciation of Services Award. Right: Mrs. John L. Wright accepting Appreciation of Services Award from Vivian Johnson.



Installation Ceremonies—(left to right) Leslie Lee, Speaker of the House; Elaine Kaiser, Recording Secretary; Mary Hildebrand, Treasurer; Velma Hukill, 2nd Vice President; Leslie Schwartz, M.D., Illinois Society Advisor; Vivian Johnson, Past President; Jean Nelson, 1st Vice President; Pat Mooney and Magda Brown, President.



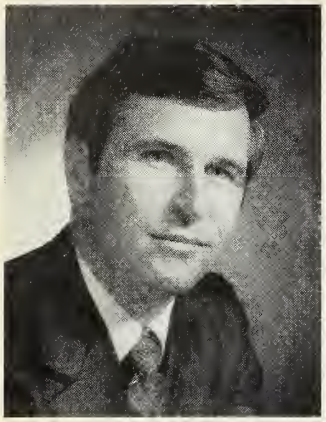
Magda Brown being instaled as President of AAMA, Illinois Society. (Left to right) Bonnie Anderson, Ruby Jackson, and Mary J. McFadden with Dr. Schwartz and Magda Brown.



Magda Brown exchanging President's gavel with Vivian Johnson, Immediate Past President.



Members of the Medical Advisory Board to AAMA, Illinois Society with Presidents. (From left) Dr. Leslie Schwartz, Dr. Robert Kramer, Dr. Allison Burdick, Sr., Madgda Brown, Illinois Society President; Vivian Johnson, Immediate Past President of the Illinois Society; Dr. John Wright, Chairman, State Advisory Committee, Dr. Carl Clark, and Dr. Thomas R. Harwood, ISMS liaison to AAMA, Illinois Society.



President's Page

Commitment to Goals

The following is adapted from Dr. Ingalls' inaugural address before the ISMS House of Delegates on April 6, 1975.

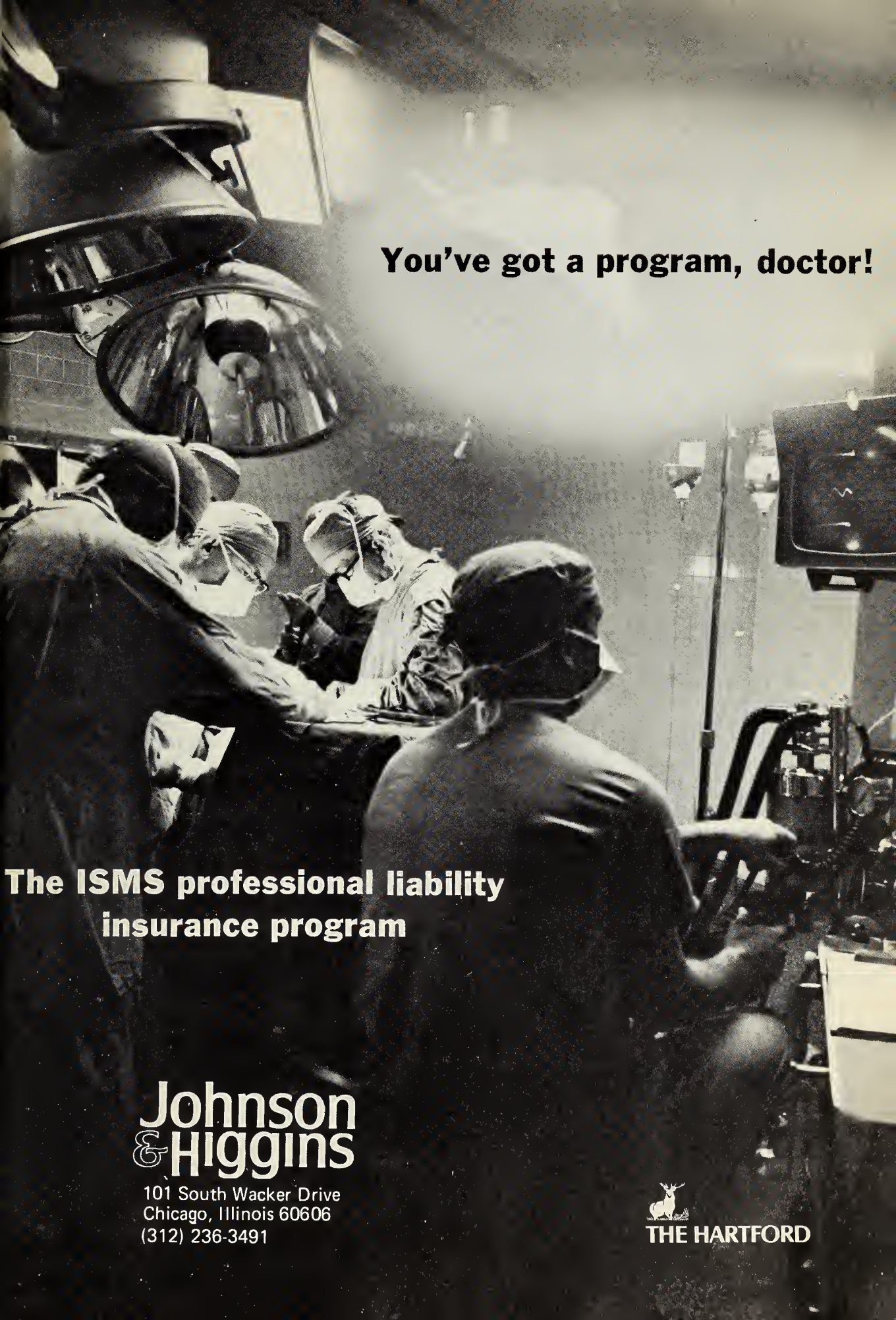
During my year as president, I will be committed on your behalf to every policy of the House of Delegates. In addition, I will endeavor to:

- Involve more physicians in the activities of ISMS.
- Insure that no faction assumes dictatorial control of any portion of this society.
- Eliminate any power-seeking or game-playing that may occur within ISMS, regardless of whether the source is the physician or the staff.
- Initiate, if necessary, the reorganization of this society in order to preserve a forum for physician representation. I cannot, and will not, passively allow a deterioration of a forum for physicians to meet and discuss—with intelligence and concern—the matters of vital importance to our profession.
- Promote consideration of our experience and our knowledge as the criteria for decisions which affect the medical care of our patients.

Most importantly, I will devote a major portion of my energies to presenting your views to the public in a proud and forthright manner.

J. M. Ingalls, M.D.

J. M. Ingalls, M.D.


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Contracts and Responsibilities

The "Housestaff News" is designed for interns and residents. News items and short articles of interest to housestaff will be considered for publication; materials should be sent to Michael Hughey, M.D., 711 Laurel Avenue, Wilmette, Ill. 60091.

By Sam Sugar, M.D./Evanston

In these times of housestaff activism in the field of medical economics and physician's rights, it might be well to consider aspects of housestaff responsibility that go hand in hand with increased benefits and privileges which are being won by interns and residents associations. Every benefit handed out has a cost.

Recently, housestaff associations have successfully used labor union negotiating procedures to establish house officers as "employees" rather than "trainees" so as to bargain for greater benefits and more reasonable wages. While this method has won concessions in salary negotiations, at the same time it may have lost the income tax deduction of $300/month for which post-graduate trainees sometimes qualify. In addition, as employees, strict limitations can be placed on the number of sick days and personal business days one may take. In the past, a resident might be able to take the afternoon off occasionlly if his work was done; in the future he might be docked for that time. Clearly a price is being paid for each battle won.

While there seems to be little justification (save hospital economics) for presently arduous call schedules, continuity of care is provided for at least the 24 hours that the house officer is on duty. Although a system of physicians on 8-12 hour shifts may be acceptable in an Emergency Room, transfer of in-patient responsibility three times a day is bound to result in some patient needs being lost in the shuffle. While few would argue that a more humane system of call scheduling has long been in order, to achieve such a system by reducing patient contact to a limited number of hours per day would promote a standard of medical practice which can only be described as amatuerish. Patients become ill day and night and a house officer can best learn his patient's problems by attending to them no matter what time of the day or night they occur. If he rejects this responsibility because it does not fit his job description he must accept the reality that his training has not been optimal or complete and that it does not reflect the burdens he will be expected to accept as a practicing physician.

Would it then not behoove that house officer to spend fewer nights but more years in his training program until his training was completed? Indeed, unless one accepts the idea that reading about a pathological process is tantamount to seeing and treating a patient with that process, perhaps medical school curricula may also need to be lengthened as students also demand less on call time. Indeed since the undergraduates job description is that of a "student of medicine" who is paying to be taught patient care, not to provide it, the night-time care of patients would be the sole responsibility of physicians who were being paid for that service. In such a system a medical student might be allowed to render patient care at night only with the permission of his dean and adequate compensation for his labor. After his stint on duty all responsibility for patients would end—after all he would not be paid for it.

Although a hospital employee's responsibility might end with patient care, a house officer's does not. He must serve as a teacher and leader to those under him. As such, he must set an example of competence, maturity, initiative and self-determination. If housestaff duties are to be spelled out in contracted job descriptions will there be a set number of minutes of required housestaff teaching which must not be exceeded? Will there be guidelines similar to those for other labor groups prescribing how many housestaff must be present to perform a spinal tap and how much "minimum time" they must take to do it? Will variance in work performance be cause for unilateral dismissal of the employee physician? Will moonlighting at competing medical institutions be allowed?

Research has a rich tradition for house officers, both as an intellectually satisfying activity and as an important contribution to medical science. As employees, will physicians be allowed to participate in research only if paid time and half? Will new thoughts and ideas become the property of the employer?

Today's medical students depend on the voluntary teaching they receive in many clinical settings both from housestaff and practitioners. In the future will students be forced to pay for teaching as agreed to by contract: indeed will they have to pay more for teaching from a senior resident than teaching from an intern?

If in the future medical costs continue to rise and contracts for housestaff services do become a reality, what safeguards are there that patient care will not become subservient to employment and business considerations. How can one be sure that once we become employees, our "bosses" will not tell us exactly how to treat a coronary victim; and if we refuse to do it exactly as the boss says, who is to say we would not be summarily fired? Indeed, how can one be sure future house officers will want to be employees rather than trainees? Once this designation is established can future physicians who dislike it change it?

There are precious few professions today where individual freedom and self-reliance have been as zealously guarded as in medicine. The tradition of American medicine has been to preserve that precious privilege of physician discretion in patient management. The price that physicians have paid through the years to retain that privilege has been awesome; training that was brutal, hours that are too long, personal and family psychotrauma —the list is endless. But through it all, physicians have tenaciously grasped the ideal that the best care for a patient today is from a doctor concerned about that patient and who can and will do what he feels is necessary

(Continued on page 583)

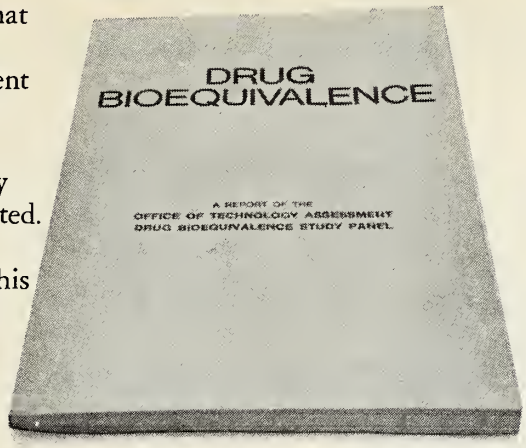
the weight of scientific opinion:

If the pharmacist substituted a chemically equivalent drug for the one you have specified for your patient—could you be certain of that product's safety and effectiveness simply because the chemical content was the same?

Definitely not, unless bioequivalence tests and other quality assurance checks had been conducted. The pharmaceutical industry and many scientists have maintained this position for years, but others have questioned it. Now the Office of Technology Assessment of the Congress of the United States has reported on the issue in its Drug Bioequivalence Study.*

Here are a few definitive statements in the O.T.A. report:

"...the problem of bioinequivalency in chemically equivalent products is a real one. Since the studies in which lack of bioequivalence was demonstrated involved marketed products that met current compendial standards, these documented instances constitute unequivocal evidence that neither the present standards for testing the finished product nor the specifications for materials, manufacturing process, and controls are adequate to ensure that ostensibly equivalent drug products are, in fact, equivalent in bioavailability.



"While these therapeutic failures resulting from problems of bioavailability were recognized and well documented, it is entirely possible that other therapeutic failures and/or instances of toxicity that had a similar basis have escaped attention."

The Pharmaceutical Manufacturers Association supports federal legislative amendments that would require manufacturers of duplicate prescription pharmaceutical products, subject to new drug procedures, to document:

(a) chemical equivalence; and

(b) biological equivalence, where bioavailability test methods have been validated as a reliable means of assuring clinical equivalence; or

(c) where such validation is not possible, therapeutic equivalence.

In addition, the PMA supports federal legislation that would require certification of all manufacturers of prescription products before they could start in business, annual inspections and certification thereafter, and strict adherence to FDA regulations on good manufacturing practices.

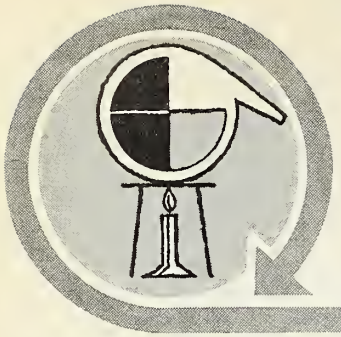
The overall quality of the United States drug supply is excellent. But only a total quality assurance program, envisaged in these and other policy positions adopted by the PMA Board of Directors in 1974, can bring about acceptable levels of performance by all prescription drug manufacturers and thereby assure the integrity of your prescription...

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

*Copies of the complete report on Drug Bioequivalence may be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

protecting the integrity of your prescription



new pharmaceutical specialties

By Paul Dehaen

For detailed information regarding indications, dosage, contraindications and adverse reactions, refer to the manufacturer's package insert or brochure.

Single Chemicals—Drugs not previously known, including new salts.

Duplicate Single Drugs—Drugs marketed by more than one manufacturer.

Combination Products—Drugs consisting of two or more active ingredients.

New Dosage Forms—Of a previously introduced product.

The following new drugs have been marketed:

SINGLE CHEMICALS

LOTRIMIN Cream — Topical Fungicide Rx

Manufacturer:	Delbay Pharmaceuticals, Inc.
Nonproprietary Name:	Clotrimazole
Indications:	Fungal infections of the skin.
Precautions:	If irritation or sensitivity develop discontinue therapy.
Dosage & Administration:	Massage gently into the affected area and surrounding skin twice a day, morning and evening.
Supplied:	Tubes, 15 and 30 Gm.; Cream 1%

DUPLICATE SINGLE DRUGS

EXPECTRAN — Cough Therapy o.t.c.

Manufacturer:	Ross Laboratories
Nonproprietary Name:	Glyceryl guaiacolate syrup N. F.
Indications:	Symptomatic relief of cough associated with respiratory disorders.
Precautions:	Not for use in chronic or recurrent cough.
Dosage:	Adults—2 teaspoonfuls every 3-4 hrs. Children—6-12 yrs., 1 teaspoonful every 3-4 hrs. Children—3-6 yrs., ½ teaspoonful every 3-4 hrs.
Supplied:	Bottles, 4 fl. oz. and 16 fl. oz. 5 ml/100 mg.

RORASUL — Sulfonamide Rx

Manufacturer:	William H. Rorer, Inc.
Nonproprietary Name:	Salicylazosulfapyridine
Indications:	Adjunctive therapy of ulcerative colitis.
Contraindications:	Those usual for sulfonamides.
Precautions:	Use with caution in patients with severe allergy or bronchial asthma.
Dosage:	4 to 8 Gms. daily and adjust to patient's response.
Supplied:	Tablets, 500 mg.

COMBINATION PRODUCTS

EXPECTRAN DM — Cough Therapy o.t.c.

Manufacturer:	Ross Laboratories
Composition:	5 ml. contains: Glyceryl guaiacolate 100 mg. Dextromethorphan Hydrobromide 15 mg.
Indications:	Symptomatic relief of cough associated with respiratory disorders.
Precautions:	Not for use in chronic or recurrent cough.
Dosage:	Adults—2 teaspoonfuls 4 times daily. Children—6-12 yrs.—1½ to 1 teaspoonful 4 times daily. Children—3-6 yrs.—¼ to ½ teaspoonful 4 times daily.
Supplied:	Bottles, 4 fl. oz. and 16 fl. oz.

XYLOCAINE HCl with Dextrose — Spinal Anesthesia Rx

Manufacturer:	Astra Pharmaceutical Products, Inc.
Composition:	Aqueous Solution: Lidocaine HCl 1.5% Dextrose 7.5%
Indication:	Selective sensory anesthesia in routine obstetrical procedures.
Contraindications & Warnings:	See package insert.
Dosage:	Low spinal or "Saddle block" anesthesia; approximately 1.25 to 1.50 ml.
Supplied:	Ampules, 2 ml.

NEW DOSAGE FORMS

LOTRIMIN Solution — Local Fungicide Rx

Manufacturer:	Delbay Pharmaceuticals, Inc.
Nonproprietary Name:	Clotrimazole
Indications:	Fungal infections of the skin.
Precautions:	If irritation or sensitivity develop discontinue therapy.
Dosage & Administration:	Massage gently into the affected area and surrounding skin twice a day, morning and evening.
Supplied:	Plastic bottles, 10 and 30 ml.; Solution 1%

NITRO-BID Ointment — Coronary Vasodilator Rx

Manufacturer:	Marion Laboratories
Nonproprietary Name:	Nitroglycerin 2% with lactose
Indication:	Prevention and treatment of angina pectoris, especially at night.
Dosage & Administration:	Apply every 3-4 hrs. and at night; 1 to 2 inches as squeezed from the tube.
Supplied:	Tubes, 60 Gm.

Model Free Clinic

(Continued from page 563)

tion drugs and another was hospital bills for those patients requiring hospitalization. We did get a large downtown drug store to agree to give half price prescriptions. To pay for these prescriptions money was solicited from several local service clubs. This is the only money that has ever been involved in this program. The patients present their prescription to this particular pharmacy in the usual fashion and receive their drugs as anyone else would. However, the bill for half the price of the prescription drugs is then sent back to the county health department where it is paid for out of the solicited drug fund. Regarding hospital costs, the local hospital agreed in 1973 not only to accept available third party payments but also not to sue for payment any people who quite obviously did not have either funds of their own or third party assistance. This appeared to be a satisfactory solution to the hospital care problem.

Summary

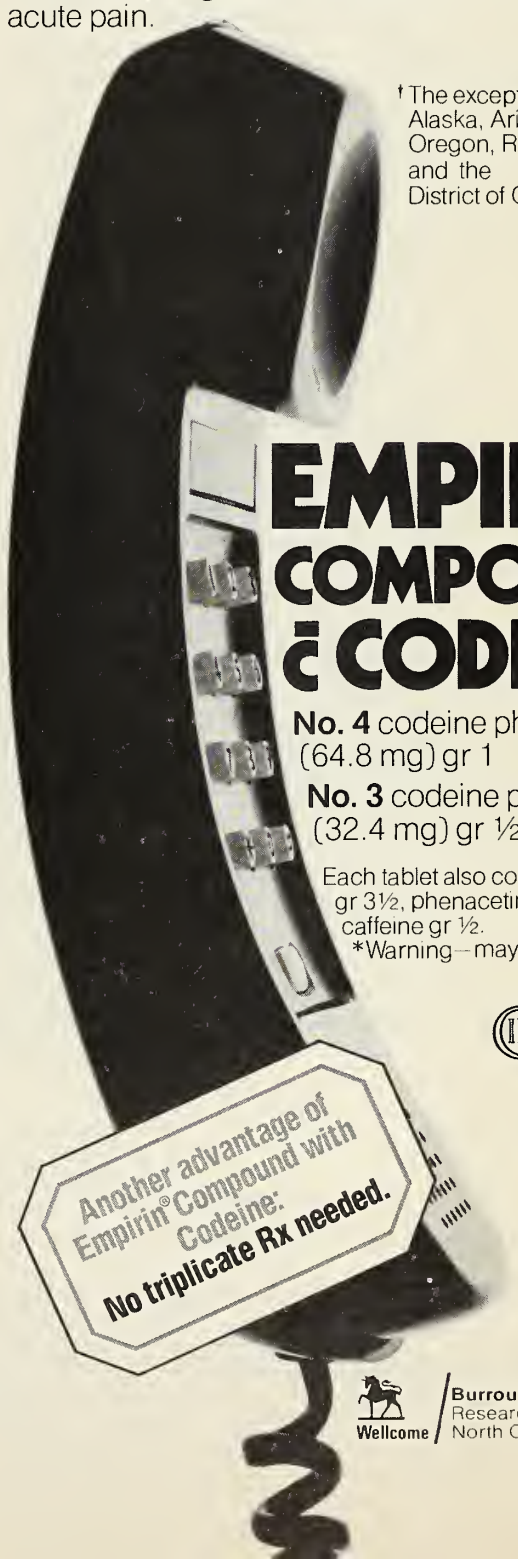
As mentioned earlier, the original idea was to maintain the dignity of these poor patients and at the same time to provide genuinely free care. The latter is emphasized because with the exception of the solicited drug money this is a truely free program. Not a single additional dollar has been expended, nor will it be despite the fact that the clinic is providing many thousands of dollars worth of free service. Freeport and Stephenson County, are no different than thousands of other similar size communities. The physicians here are the same moderately conservative type of individuals found in medical communities throughout this country. The program established here requires only the commitment of the local health care professionals and the county health department. It could be established anywhere in the United States. In the larger metropolitan communities similar mechanisms could be employed, although there it seems apparent that some fulltime physicians would be required. There are agencies in the country that do assist in fulltime medical help in such cases. These few fulltime physicians could, however, enlist these same kind of volunteer backup services as we have in this community so as to minimize the cost of medical care.

Finally I think we have accomplished two worthwhile goals. The first is that we provide high quality free service to those in need. Secondly, we have demonstrated to people in general our desire and capacity to provide quality at a cost no government program could ever approach. ◄

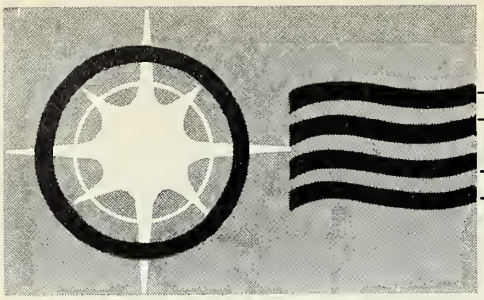
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Dear Editor:

I have been thinking of writing an article or book on the unwritten laws of human behavior that one encounters in the medical field.

Some general laws I've observed, for example, are Murphy's Law—"If anything can go wrong it will." I understand there is a refinement of Murphy's Law—"When things go wrong somewhere, they are apt to go wrong everywhere." And "Good parking places are always on the other side of the street." "Events that never should happen, usually do. When such events occur, there is always someone who knew they would." Finagle's First Law submits "In any operation, if something can go wrong, it will. Moreover, it will go wrong even when it can't."

Here are some laws I have made up related to the specialty of allergy:

The Decibel Law states, "The number of cigarettes the asthmatic is still smoking is in inverse proportion to the loudness of his voice when he says 'I've stopped'."

The Law of Rover states that a patient's expression "Ole' Rover hardly ever comes in the house" really means "Ole' Rover sleeps on the foot of my bed."

The Law of Felix states that the statement "My cat never comes inside" is an incomplete sentence, the completion of which reads "except when I am home."

If you know of any certain laws that establish themselves with physicians, I'd appreciate hearing them. For example, Dr. Irwin S. Eskwith formulated a law, "Patient loyalty is inversely proportionate to physician availability." Can other physicians think of similar laws pertaining to their specialty. If so, I'd appreciate your sending them to:

Claude A. Frazier, M.D.
4-C Doctors Park
Asheville, N.C. 28801

Sincerely,
Claude A. Frazier, M.D.

Beg Your Pardon: In the April IMJ index Richard Ablin was inadvertently designated as an M.D. and William Curtis was misspelled. As correctly indicated within the book, Richard Ablin is a Ph.D. and William Curtis, M.D. is spelled right.

Dear Dr. Van Dellen:

My article read well and I received a very great deal of favorable comments on it. Enclosed are copies of two representative letters from youngsters like Eloise and Leon, both of whom were our teachers and would like to be around in 2001 A.D. to check on our box score.

Sincerely,
Louis D. Boshes, M.D.
Clinical Professor of Neurology
and Director

Dear Dr. Boshes:

One always considers predictions generally made in relation to ones-self. I was born in 1895 and in 2001 I will be 106 years old. Considering the fact that the longevity of women increases, at 106 (even without a brain transplant) I should be intellectually alert in 2001.

I must have been clairvoyant when, at the age of 75, I retired from the practice of Obstetrics, for in 2001 babies will be ordered from laboratories and the specialty of Obstetrics will be obsolete.

How fortunate I was that I retired to the farm. Now in 2001 my interest in food, energy, ecology and social planning will be in great demand.

Your predictions were certainly thought provoking.

Yours truly,
Eloise Parsons, M.D.

Dear Louis:

Just want to congratulate you on a marvelous article which appeared in the Illinois Medical Journal in April. Your title "Medicine 2001 A.D." certainly makes one think of the future of the practice of medicine and I think you have analyzed each specialty very well. Perhaps you did not give enough time or place to allergy-immunology. As a matter of fact if you will consult the April, 1975 chapter of our new book entitled STEPPING STONES IN ALLERGY you will see that the last chapter is called a "View from the Plateau." It deals with past, present and future views on allergy and immunology.

In any case, best wishes and congratulations again.

Sincerely,
Leon Unger, M.D.

Housestaff News

(Continued from page 576)

for that patient's well-being. Patients have come to expect no less from us and physicians alone or in teams can provide no less if they claim to practice high quality medicine. Those who would dilute this standard of care in the interest of an easier, more structured life style are most assuredly well intentioned and are to be commended for trying to effect what they consider to be progress. But viewed in perspective, there is a real threat that in these efforts to improve physicians life styles, the freedom of thought and action that physicians now enjoy may be usurped by the transformation of physicians into contracted medical workers. This threat may be present in some forms of practice agreements also currently in vogue, but it is clearly an imminent danger to house officers and organizations who feel that binding arbitration is the quickest way, to achieve reforms and correct grievances. Perhaps it is the quickest way, but it is also the most permanently binding way to limit housestaff freedoms.

There is no questions that house officers have been and are being abused by the system they seek to change. But unless we physicians realize that we give up intellectual and personal freedoms each time we further reduce our traditional role in medicine, we stand in danger of becoming no more than highly skilled, unthinking, unfeeling 40 hour a week plus overtime medical laborers. Would it not be better if the leaders of university and hospital teaching programs could openly and honestly propose humane and efficient ways of training physicians to equally sincere and honest housestaff representatives without labor arbitrators? The alternative is contractual agreements for the training of something less than doctors and the development of something less than a profession among those who practice the medicine of the future.

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Appendicitis In Infants: A Historical Notation

By Ronald D. Greenwood, M.D./Massachusetts

A little boy, 9 months of age, entered the hospital on January 5th, with a temperature of 105 F; pulse, 156; respiration, 50. He had suffered from bronchitis almost since birth. The baby became acutely ill on Tuesday, January 2nd, was feverish, restless, and cried; the following day, January 3rd, he vomited 3 times and was obstinately constipated. On January 4th the patient became decidedly more feverish and drowsy; respiration was difficult and somewhat noisy. Before entering the hospital the baby had a severe coughing attack and vomited some dark bloody fluid. During his stay in the hospital the fever continued high, the pulse rapid, respirations were recorded as high as 64, 80, and 100; there was twitching of eyelids and facial muscles. The bowels moved; vomiting continued; the temperature rose to 106 F; respirations continued exceedingly rapid; pulse irregular. The abdomen, which was distended during the first day or two in the hospital, became flat. The child died.

Autopsy was made shortly after death by Dr. Oscar Schultz, pathologist in chief, and Doctor Perlstein. On opening the peritoneal cavity, a yellowish creamy pus escaped. The intestines were covered with stringy fibrin. The region of the appendix contained much pus and a large accumulation of fibrinous exudate. On closer examination, it was found that the appendix had perforated, and a large fecal concretion was discovered in its lumen. A direct smear from the pus showed the presence of colon bacilli.

In this young infant, the diagnosis of abdominal disease was difficult, the possibility of a perforative appendicitis in a 9 months old child seeming remote.

The year was 1917, and the case summary was written by Isaac A. Abt of Chicago. Appendicitis in infancy was not generally recognized. One of the first cases in the literature was reported by Holmes in May 1847; in fact, in 1917 there existed in the literature only about 80 cases in infants under two years of age. Dr. Abt described the symptoms and physical findings carefully and clearly so the practitioners of the day would detect the true diagnosis.

> The symptoms of appendicitis in infants show such marked variations from those which occur in older children and adults, that the presence of the disease in very young children is worthy of special attention.

At the time of this work, Abt was Professor of Pediatrics at Northwestern University Medical School. During his life (1867-1955), Abt made numerous contributions to pediatrics.

Reference

1. Abt, I. A.: "Appendicitis in infants." *Arch. Pediatrics* 34:641-57, 1917.

BUSINESSMEN SHOULD TURN ACTIVISTS

"I think it's time for more business people, working through their organizations and acting independently as private citizens, to take a more energetic, active part in political and social causes to preserve and perfect our economic and political systems for the good of all the people. Perhaps the day will come when business people can call each other activists and like it."—O. Pendleton Thomas, Chairman, B. F. Goodrich Co.

TAX CREDIT BOOSTED ON BUSINESS TRAVEL

Effective Jan. 1, 1975, the standard mileage rate for federal tax purposes has been increased by three cents a mile for the first 15,000 miles and one cent a mile for each additional mile of business use of automobiles, according to *Association Taxation*, a newsletter published by the Chamber of Commerce of the United States. The standard mileage rates will become 15 cents on the first 15,000 miles and 10 cents on each additional mile.

EKG

(Continued fram page 557)

Anwsers: 1. B,D 2. A,B,C,D,E

Right bundle branch block and acute anteroseptal myocardial infarction has developed. The conduction abnormality is diagnosed by QRS prolongation to 0.13 seconds with terminal delay as manifested by large S waves in leads I, AVL, and V_5 and V_6. The pathologic Q waves in V_1-V_4 suggest presence of anteroseptal myocardial infarction. ST segment elevation of recent onset dates the infarct as acute.

Up to 20% of acute anterior wall infarcts may develop transient hypertension. Patients with acute myocardial infarction who develop new LBBB, RBBB, or bifascicular block, especially with anterior wall infarction, will frequently progress to high grade A-V block requiring pacing. The heart block may often begin with sudden prolonged asystole. Some have recommended prophylactic pacemaker insertion in these patients. The mortality is very high reflecting extensive damage to septum and the trifasciular conduction system. Norris and Croxson reported a 7% incidence of RBBB with a 61% mortality and a 4% incidence of LBBB with a 48% mortality. If heart block did not occur there was a 59% mortality compared to 85% if heart block did occur. This mortality is not significantly changed by pacing, since the cause of death is usually cardiogenic shock and/or left ventricular failure (*American Heart Journal* 79: 728, 1970).

Shaking The Monetary Tree

Oil-exporting nations are expected to accumulate approximately $60 billion in oil revenues by the end of this year, yet can usefully absorb only $10 billion in developing their countries.

"The U.S. share of this flow of funds is calculated to be 25% of the total," comments Charles H. Smith, Jr., chairman of the Board of Directors of the Chamber of Commerce of the United States.

"Without some major changes in the current situation, this kind of horrendous capital transfer threatens to destroy the already shaky world monetary system as well as create havoc in the industrialized nations of Europe, North America and Japan."

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Cancer Death Rate Tied to Air Pollution

Some urban factor, most likely air pollution, is responsible for increased mortality due to cancer in the United States, Dr. Amasa B. Ford said at the annual meeting of the American Public Health Association in New Orleans.

Mortality from all cancers is highest in metropolitan counties with a large central city, and it is lowest in nonmetropolitan counties, said Dr. Ford, of the Case Western Reserve University School of Medicine, Cleveland.

When cancer deaths are examined by specific tumor types, the same association with urban life is seen for cancers of the breast and of the digestive, respiratory, and urinary tracts.

Only cancers of the genital tract and leukemia are not significantly linked to place of residence.

When mortalities were adjusted for age, sex, or race, the same consistent pattern was observed, Dr. Ford said.

Air pollution measurements and cancer deaths were compared for Cuyahoga County, Ohio, from 1969 to 1971. Death rates from all types of cancer were significantly higher in the zones of maximal pollution in central Cleveland.

The risk of cancer mortality in the zone of highest air pollution was 1.4 times as high as the risk in the zone of least air pollution, Dr. Ford reported.

Health Ranking of Chicago Communities

"Age, Death, Doctors, and Hospitals, a Health Ranking of Chicago's 76 Community Areas-Utilizing Four Key Indices" is the title of a recent publication by John D. Deene for the Center for the Study of Patient Care and Community Health at the School of Public Health, Medical Center Campus, University of Illinois.

This publication is a report of key indices which describe the health status of Chicago's residents and are based upon several guidelines, including acceptability as overall indicators, availability of component data, applicability to health generalizations, and currency as well as statistical considerations such as validity and reliability. The city wide statistics will not only enable intercommunity comparisons and evaluations of varied geographic components of Chicago but will also help to enhance the decision-making planning processes of health-oriented community groups and more formal health planning organizations.

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References should be numbered in order of appearance in the text and conform to the following style in the order given: name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Make drawings and charts in black ink. If photographs are submitted, send black and white glossies. Number illustrations consecutively and indicate their place in the text. Number, indicate the top and place the author's name on the back of each illustration.

Address manuscripts to:

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